ORIGINAL-
Application

MUA of Middle Tennessee, LLC

CN1308-030

CERTIFICATE OF NEED APPLICATION

for the

Addition of Interventional Pain Management Services
to an existing ASTC

by

MUA of Middle Tennessee, LLC
28 White Bridge Rd # 210
Nashville, TN 37205

STATE OF TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
ANDREW JACKSON BUILDING
500 DEADERICK STREET, SUITE 850
NASHVILLE, TENNESSEE 37243

Filing Date: August 15, 2013

SECTION A: APPLICANT PROFILE

1. Name of Facility, Agency or Institution

2013 AUG 15 PM 2 32

MUA of Middle Tennessee, LLC
Name

28 White Bridge Road, #210 — Davidson
Street or Route — County

Nashville, — TN — 37205
City — State — Zip Code

2. Contact Person Available for Responses to Questions

E. Graham Baker, Jr. — Attorney
Name — Title

Weeks and Anderson — graham@grahambaker.net
Company Name — e-mail address

2021 Richard Jones Road, Suite 350 — Nashville, — TN — 37215
Street or Route — City — State — Zip Code

Attorney — 615/370-3380 — 615/221-0080
Association with Owner — Phone Number — Fax Number

3. Owner of the Facility, Agency, or Institution

MUA of Middle Tennessee, LLC — 615-352-3000
Name — Phone Number

28 White Bridge Road, #210 — Davidson
Street or Route — County

Nashville, — TN — 37205
City — State — Zip Code

4. Type of Ownership of Control (Check One)

A.	Sole Proprietorship	____	F.	Governmental (State of Tenn. or Political Subdivision)	____
B.	Partnership	____	G.	Joint Venture	____
C.	Limited Partnership	____	H.	Limited Liability Company	x
D.	Corporation (For-Profit)	____	I.	Other (Specify)	
E.	Corporation (Not-for-Profit)	____		_____	____

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS. See *Attachment A.4.*

SECTION A:

APPLICANT PROFILE

Please enter all Section A responses' on this form. All questions must be answered. If an item does not apply, please indicate "N/A". ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment.***

Section A, Item 1: Facility Name must be applicant facility's name and address must be the site of the proposed project.

Response: MUA of Middle Tennessee, LLC ("Applicant") is the Applicant. See Response to A.1. The Applicant is currently located at 28 White Bridge Road, Suite 210, Davidson County, TN 37205, which is the site of the proposed project.

Section A, Item 3: Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence, if applicable, from the Tennessee Secretary of State.

Response: See *Attachment A.4*.

Section A, Item 4: Describe the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% or more ownership interest. In addition, please document the financial interest of the applicant, and the applicant's parent company/owner in any other health care institution as defined in Tennessee Code Annotated, §68-11-1602 in Tennessee. At a minimum, please provide the name, address, current status of licensure/certification, and percentage of ownership for each health care institution identified.

Response: The Applicant is owned by its five members, and is member-managed. There is no organizational chart.

The five members of the Applicant are Lance C. Benedict, D.C. (21.5%), Terry Totty, D.C. (21.5%), Paul Yim, M.D. (12%), Mr. Michael Goorevich (6%), and Robert Odell, M.D. (39%).

The Applicant does not own any other health care institution in Tennessee, as defined in TCA §68-11-1602.

Section A, Item 5: For new facilities or existing facilities without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract

Please describe the management entity's experience in providing management services for the type of the facility, which is the same or similar to the applicant facility. Please describe the ownership structure of the management entity.

Response: Not applicable, as there is no management entity.

Section A, Item 6: For applicants or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the tide/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements must include anticipated purchase price. Lease/Option to Lease Agreements must include the actual/anticipated term of the agreement and actual/anticipated lease expense. The legal interests described herein must be valid on the date of the Agency's consideration of the certificate of need application.

Response: The Applicant sub-leases space from Tennessee Spine and Nerve Institute, Inc., which currently leases the space from NOL, LLC, the landlord.

Attachment A.6 is a copy of the lease between the landlord and Tennessee Spine and Nerve Institute, Inc., and a *Attachment A.6.1* is an Assignment Agreement whereby the Applicant took over the existing lease from the Tennessee Spine and Nerve Institute, Inc., for the 1,493.4 GSF, the site of its specialty ASTC, already approved.

5. Name of Management/Operating Entity (If Applicable)

Not applicable
Name

Street or Route County

City State Zip Code

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS. Not applicable.

6. Legal Interest in the Site of the Institution (Check One)

A.	Ownership		D.	Option to Lease	
B.	Option to Purchase		E.	Other (Specify)	
C.	Lease of 6 Years	x			

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS. See *Attachments A.6 and A.6.1.*

7. Type of Institution (Check as appropriate--more than one response may apply.)

A.	Hospital		I.	Nursing Home	
B.	Ambulatory Surgical Treatment Center (Multi-Specialty)		J.	Outpatient Diagnostic Center	
			K.	Recuperation Center	
C.	ASTC	X	L.	Rehabilitation Facility	
D.	Home Health Agency		M.	Residential Hospice	
E.	Hospice		N.	Non-Residential Methadone Facility	
F.	Mental Health Hospital				
G.	Mental Health Residential Treatment Facility		O.	Birthing Center	
			P.	Other Outpatient Facility (Specify)	
H.	Mental Retardation Institutional Habilitation Facility (ICF/MR)		Q.	Other (Specify) specialty ASTC	X

8. Purpose of Review (Check as appropriate--more than one response may apply.)

A.	New Institution		H.	Change In Bed Complement (Please note the type of change by underlining the appropriate response: Increase, Decrease Designation, Distribution Conversion, Relocation)	
B.	Replacement/Existing Facility				
C.	Modification/Existing Facility	X			
D.	Initiation of Health Care Service as defined in TCA § 68-11-1607(4)				
			I.	Change of Location	
E.	Specify		J.	Other (Specify) add interventional pain mgmt services	X
F.	Discontinuance of OB Services				
G.	Acquisition of Equipment				

9. Bed Complement Data

Please indicate current and proposed distribution and certification of facility beds.

2013 AUG 15 PM 2 32

Response: Not applicable, as no beds are involved in this application.

	Current Beds Licensed	Current Beds CON*	Staffed Beds	Beds Proposed	TOTAL Beds at Completion
A. Medical					
B. Surgical					
C. Long-Term Care Hospital					
D Obstetrical					
E. ICU/CCU					
F. Neonatal					
G. Pediatric					
H. Adult Psychiatric					
I. Geriatric Psychiatric					
J. Child/Adolescent Psychiatric					
K. Rehabilitation					
L. Nursing Facility (non-Medicaid Certified)					
M. Nursing Facility Level 1 (Medicaid only)					
N. Nursing Facility Level 2 (Medicare only)					
O. Nursing Facility Level 2 (dually-certified)					
P. ICF/MR					
Q. Adult Chemical Dependency					
R. Child & Adolescent Chemical Dependency					
S. Swing Beds					
T. Mental Health Residential Treatment					
U. Residential Hospice					
TOTAL					

*CON Beds approved but not yet in service

10. **Medicare Provider Number** 103G495427
Certification Type Specialty ASTC

11. **Medicaid Provider Number** 1531024
Certification Type Specialty ASTC

12. **If this is a new facility, will certification be sought for Medicare and/or Medicaid?**

Response: This is an existing facility, certified for both Medicare and Medicaid.

13. ***Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.*** **Will this project involve the treatment of TennCare participants? Yes If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted *or plans to contract. Discuss any out-of-network relationships in place with MCOs/BHOs in the area.***

Response: The Applicant has contracts with:

BLUECARE
AMERIGROUP
TENNCARE SELECT
BLUE ADVANTAGE
SECURE HORIZON
HUMANA GOLD CHOICE/EMERALD PLAN/DIAMOND PLAN
HEALTHSPRING MEDICARE ADVANTAGE PLAN
HEALTHSPRING COVENTRY
WINDSOR / MEDICARE EXTRA
GOLDEN RULE
UNITED MEDICAL RESOURCES
HERITAGE SELECT
STERLING OPTIONS I & II
MEDICARE COMPLETE
PYRAMID LIFE INSURANCE COMPANY
SEDGWICK
TODAY'S OPTIONS
UHC PLAN OF RIVER VALLEY
MEDICARE RAILROAD (RETIREMENT BOARD) FOR RAILROAD EMPLOYEES
DME CONTRACTORS FOR MEDICARE:
NATIONAL GOVERNMENT SERVICES: FOR REGION B
NORIDIAN FOR REGION D AND REGION A

Further, the Applicant will contract with any available or new MCOs as needed.

NOTE: ***Section B is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project. Section C addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.***

SECTION B: PROJECT DESCRIPTION

Please answer all questions on 8 1/2" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

Response: MUA of Middle Tennessee, LLC ("Applicant"), 28 White Bridge Road, #210, Nashville, Davidson County, TN 37205, owned and managed by itself, files this application for a Certificate of Need for the addition of interventional pain management services at its ASTC. The Applicant currently provides manipulation under anesthesia ("MUA") services. This new service will be provided in the same one procedure room which is currently licensed. There are no beds and no major medical equipment involved with this project. No other health services will be initiated or discontinued. It is proposed that Medicare, TennCare, commercially insured, and private-pay patients will be served by the ASTC, which will be licensed by the Tennessee Department of Health. The estimated project cost is anticipated to be approximately $113,000, which includes the $3,000 filing fee.

MUA of Middle Tennessee, LLC is the Applicant. See response to A.1. The Applicant is currently located at 28 White Bridge Road, #210, Nashville, Davidson County, TN 37205.

The five members of the Applicant are Lance C. Benedict, D.C. (21.5%), Terry Totty, D.C. (21.5%), Paul Yim, M.D. (12%), Mr. Michael Goorevich (6%), and Robert Odell, M.D. (39%).

The Applicant sub-leases space from Tennessee Spine and Nerve Institute, Inc., which currently leases the space from NOL, LLC, the landlord. *Attachment A.6* is a copy of the lease between the landlord and Tennessee Spine and Nerve Institute, Inc., and a *Attachment A.6.1* is an Assignment Agreement whereby the Applicant took over the existing lease from the Tennessee Spine and Nerve Institute, Inc., for the 1,493.4 GSF, the site of its specialty ASTC, already approved.

Physicians have expressed concern about the treatment of chronic pain. Chronic pain has both chemical and mechanical components. Such treatment is difficult, sometimes ineffective, and has risks. These risks include narcotic abuse, misuse and diversion, and infection (such as Epidural Steroid Injections). There appears to be general consensus that a procedure that could significantly lower pain scores, improve functional capacity, and reduce narcotic use would be invaluable in the treatment of chronic pain. Manipulation under Anesthesia ("MUA") is such a procedure, and the Applicant is already approved for this service.

MUA is a modality which has been used by practitioners (doctors of chiropractic, doctors of osteopathic medicine, and medical doctors) since the early 1930s. The process involves relaxing the patient (with

anesthesia), and making corrections to biomechanical abnormalities by stretching and manipulation. Following the procedure, the patient gains a range of motion and/or relief of pain.

The Applicant is forced by insurers to attempt less intensive pain relief methods prior to attempting traditional MUA. These measures include interventional pain management services such as joint injections. The HSDA originally determined that such procedures were included under MUA, and the Applicant provided such procedures for some time. Later, the HSDA determined that the Applicant is not approved for such interventional pain management services. Since the Applicant cannot conduct the MUA procedures for which it has already been approved without attempting interventional pain management procedures first, this application is being filed.

Project Costs: There are no costs, other than administrative, for this project. The facility, as approved and licensed, will not require any modification. The FMV and lease costs for the ASTC have already gone through CON when the ASTC was approved. Equipment is already in place.

Staff: The Applicant will utilize existing staff, including an administrator ($12K - $15K annually), a receptionist ($13/hour), RN ($25K-$30K annually), and a Rad Tech ($20- $23/hour). No additional staff will be needed for this project.

Charges: The Applicant anticipates an average gross charge per patient in Year 1 of operation of $1,345, with an average deduction of $1,076, for an average net charge of $269 per patient. Interventional pain management procedures can be performed in physician's offices, in hospitals, and in other approved facilities. However, it is difficult, and almost impossible, to arrive at comparable charges for such services since such charges are not reported on Joint Annual Reports. The Applicant has made an attempt to compare these charges, as will be discussed later in the application.

Procedures: It is projected that 3,455 and 4,442 interventional pain management procedures will be performed in years 1 and 2, respectively. These projections are based on historical utilization at the Applicant's facility, coupled with anecdotal information retrieved from several doctors in the Nashville area.

Medicare and TennCare Revenue Projections: It is anticipated that 40% of our patients will be Medicare, 10% will be Medicaid, 45% will be commercial patients and 5% will be private pay.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $5 million) and other facility projects (construction cost in excess of $2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above, describe the development of the proposal.

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Procedures: It is projected that 3,455 and 4,442 interventional pain management procedures will be performed in years 1 and 2, respectively. These projections are based on historical utilization at the Applicant's facility, coupled with anecdotal information retrieved from several doctors in the Nashville area.

Medicare and TennCare Revenue Projections: It is anticipated that 40% of our patients will be Medicare, 10% will be Medicaid, 45% will be commercial patients and 5% will be private pay.

The current ASTC room configuration is noted on *Attachment B.IV.* Note that there is only one Procedure Room. This room is already approved, and will be utilized for interventional pain management services. It is also important to note that only one patient will be served at a time, and each patient will receive only one service during a visit. Some procedures require mild sedation, and anesthesia will be administered by either an Anesthesiologist or a CRNA working for an Anesthesiologist. Patients must have medical clearance for anesthesia. Also, patients have to have had testing for the procedure (standard testing is CBS/Diff and sometimes an SMA6). If the patient is over 50 years of age, they will need an EKG; if the patient has a history of respiratory difficulty, a Chest X-Ray will be required. Finally, a pregnancy test will be given to female patients.

Both the person administering anesthesia and the recovery room nurse must be ACLS certified in life support. Following the procedure, each patient will go to the Recovery Room for gentle stretching and physical therapy, including Interferential (electrical stimulation) therapy, and then ice. Following this, the patient will have a massage prior to discharge.

Following the procedure, most patients are fully capable of ambulation. However, in some instances it may be advised that someone (either our staff, a family member, or friend) drive the patient to their destination in order for the patient to receive rest and relaxation.

The Applicant has worked with both the HSDA and the Tennessee Department of Health, Division of Licensing Health Care Facilities, to coordinate useful licensing requirements and utilization standards for facilities such as have been approved for this ASTC. Representatives of the Applicant have met with a representative of the Board for Licensing Health Care Facilities in this regard. For example, please see *Attachment C.N.5* for a copy of working protocols for MUA procedures.

According to the Tennessee Department of Labor and Workforce Development, there are no published reports available indicating the personnel positions required for the operation of a specialty ASTC. As the publishing of such information might be considered a violation of Anti-Trust, existing ASTCs cannot get together and decide on what salaries to pay for these positions. Our existing salaries will be commensurate with both abilities and the marketplace, and the Applicant will maintain that staff. *Attachment C.OD.3* contains affiliated health care workers data.

The Applicant works with area training programs to allow students to rotate though our facility to complete clinical training requirements. Further, doctors have been trained in the clinic, and this process will continue.

B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

Response: Not applicable, as no beds are involved in this project.

C. As the applicant, describe your need to provide the following health care services (if applicable to this application):

1. Adult Psychiatric Services
2. Alcohol and Drug Treatment for Adolescents (exceeding 28 days)
3. Birthing Center
4. Burn Units
5. Cardiac Catheterization Services
6. Child and Adolescent Psychiatric Services
7. Extracorporeal Lithotripsy
8. Home Health Services
9. Hospice Services
10. Residential Hospice
11. ICF/MR Services
12. Long-term Care Services
13. Magnetic Resonance Imaging (MRI)
14. Mental Health Residential Treatment
15. Neonatal Intensive Care Unit
16. Non-Residential Methadone Treatment Centers
17. Open Heart Surgery
18. Positron Emission Tomography
19. Radiation Therapy/Linear Accelerator
20 Rehabilitation Services
21. Swing Beds

Response: Not applicable.

D. Describe the need to change location or replace an existing facility.

Response: Not applicable.

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $1.5 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. For fixed-site major medical equipment (not replacing existing equipment):

a. Describe the new equipment, including:

1. Total cost; (As defined by Agency Rule)
2. Expected useful life;
3. List of clinical applications to be provided; and
4. Documentation of FDA approval.

b. Provide current and proposed schedules of operations.

Response: Not applicable.

2. For mobile major medical equipment:
a. List all sites that will be served;
b. Provide current and/or proposed schedule of operations;
c. Provide the lease or contract cost.
d. Provide the fair market value of the equipment; and
e. List the owner for the equipment.

Response: Not applicable.

3. Indicate applicant's legal interest in equipment (*i.e.*, purchase, lease, etc.) In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

Response: Not applicable.

III. (A) Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which must include:

1. **Size of site (*in acres*)**
2. **Location of structure on the site; and**
3. **Location of the proposed construction.**
4. **Names of streets, roads or highway that cross or border the site.**

Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.

Response:

1. The site on which the medical building is located is approximately 2.31 Acres.

2. See *Attachment B.III.2.*

3. There is no construction. See *Attachment B.III.3* to show the location of the existing ASTC.

4. The ASTC is located in existing space on the second floor of the office building located at 28 White Bridge Road, Nashville, Tennessee. The site has easy access to White Bridge Road, which is a major East/West corridor connecting West End Avenue with Charlotte Pike and I40 in the western section of Nashville. The site is perhaps 10 minutes drive time from downtown Nashville.

(B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Response: Buses run on White Bridge Road, West End Avenue, and Charlotte Pike, and private taxis are also available. As the site of the proposed facility is on White Bridge Road, the site is readily accessible for patients.

IV. Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper.

NOTE: *DO NOT SUBMIT BLUEPRINTS*. Simple line drawings should be submitted and need not be drawn to scale.

Response: Please see *Attachment B.IV*, which contains a footprint of that section of the second floor of the office building where the ASTC is located.

V. For a Home Health Agency or Hospice, identify:

1. **Existing service area by County;**
2. **Proposed service area by County;**
3. **A parent or primary service provider;**
4. **Existing branches; and**
5. **Proposed branches.**

Response: Not applicable.

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines for Growth), developed pursuant to Tennessee Code Annotated §68-11-1625.

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper*. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)."

QUESTIONS

NEED

1. **Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.**

   a. **Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.**

Response: Please see *Attachment Specific Criteria.*

   b. **Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c).**

Response: Not applicable.

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any.

Response: There is no long-range development plan of the Applicant, other than to add interventional pain management services to this existing ASTC. The Applicant was originally approved to provide MUA services. After licensure, the Applicant began providing the service, and insurers advised the Applicant that they would not reimburse for MUA unless and until interventional pain management services were attempted first. The Applicant requested a determination from the HSDA as to whether or not such procedures were "covered" under the heading of MUA. Obviously, the Applicant felt they were covered. The HSDA agreed, and the Applicant resumed providing services in compliance with both Licensure and third party insurers. Later, the HSDA decided that the Applicant was not approved for interventional pain management procedures, and the Applicant had to shut down its operation. After several meetings and exchange of information among the interested parties, the Applicant decided to apply for interventional pain management services via this application.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).

Response: The Applicant's service area consists of Davidson, Williamson, Rutherford and Robertson Counties (patient origin of 98% of the patients of Tennessee Spine and Nerve Institute, Inc., in 2009, in order by county).

See *Attachment C.N.3* for a map of the proposed service area.

It is important to note that the service area for this project is based, in large part, on the actual patient origin information for two of the member/owners of the Applicant. Drs. Benedict and Totty currently serve patients from about 7 Middle Tennessee Counties, and the four top counties, in order of number of patients, are: Davidson, Williamson, Rutherford and Robertson Counties.

4. A. Describe the demographics of the population to be served by this proposal.

Response: The primary area to be served (Davidson, Williamson, Rutherford and Robertson County residents) is an urban community with rural and industrial influences. Davidson County is the hub of Middle Tennessee, and the population numbers of some of the counties in Middle Tennessee are increasing at a high rate (e.g., Williamson and Rutherford Counties). Metropolitan Nashville/Davidson County is also the hub of the Nashville-Murfreesboro Standard Metropolitan Statistical Area (SMSA) in Middle Tennessee. Please see *Attachment C.N.4.A* for a listing of Quick Facts about the four counties in our service area.

The following chart lists 2013, 2015 and 2017 population estimates for the service area:

Population Estimates for Service Area

County	Estimated 2013 Population	Estimated 2015 Population	Estimated 2017 Population
Davidson	605,923	614,222	622,476
Williamson	188,259	196,824	203,870
Rutherford	261,331	271,112	278,888
Robertson	69,680	72,006	73,853
TOTAL	1,125,193	1,154,164	1,179,087

Source: Population Estimates and Projections, Tennessee Counties and the State, 2010 – 2020, Office of Health Statistics, Bureau of Health Informatics, Tennessee Department of Health.

Attachment C.N.4.A contains demographic data for the service area. This data was obtained from the US Census Bureau.

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response: There are no special needs of the service area population, as contemplated by this question. The Applicant feels that there are individuals in need of interventional pain management services, in addition to the approved MUA services, however.

5. Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

Response: There are several hospitals and ASTCs in the service area that provide interventional pain management services. None of these facilities provide such services in conjunction with MUA, however. MUA protocols are included as *Attachment C.N.5*.

Attachment C.N.5.A is a list of all hospitals in the service area that report performing pain management services. None of these hospitals are exclusively dedicated to pain management.

Attachment C.N.5.B is a list of all ASTCs in the service area that report performing pain management services. Four of these ASTCs appear to be exclusively dedicated to pain management.

The fact that no existing hospitals are dedicated to pain management is not a derogatory statement. It merely points out the fact that the Applicant will not be able to compare our anticipated charges with the charge information from these existing providers. The Joint Annual Reports do not segregate costs/charges by service. See *Attachment C.N.5.C* which shows charge information for the 4 ASTCs which are apparently providing pain management services, only. Please note that the anticipated charges by the Applicant are significantly lower than these 4 ASTCs.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

Response: There is not sufficient historical utilization for the Applicant due to the fact interventional pain management services were just starting to be provided for a time, prior to the HSDA reversing that approval.

Procedures: It is projected that 3,455 and 4,442 interventional pain management procedures will be performed in years 1 and 2, respectively. These projections are based on historical utilization at the Applicant's facility, coupled with anecdotal information retrieved from several doctors in the Nashville area.

ECONOMIC FEASIBILITY

1. **Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.**

-- **All projects should have a project cost of at least $3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)**

-- **The cost of any lease should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater.**

-- **The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.**

-- **For projects that include new construction, modification, and/or renovation; documentation must be provided from a contractor and/or architect that support the estimated construction costs.**

Response: The Project Costs Chart is completed. This Application includes administrative costs, and a relatively small amount for equipment, only, and there is no construction or renovation. The higher of FMV and/or lease costs for the site were approved when the original ASTC was approved.

PROJECT COSTS CHART

A. Construction and equipment acquired by purchase.

2013 AUG 15 PM 2 32

1.	Architectural and Engineering Fees	
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant	50,000 .00
3.	Acquisition of Site	
4.	Preparation of Site	
5.	Construction Costs (Possible Renovation)	
6.	Contingency Fund	
7.	Fixed Equipment (Not included in Construction Contract)	
8.	Moveable Equipment (List all equipment over $50,000) (NONE OVER $50K)	60,000 .00
9.	Other (Specify)	
	Subsection A Total	**110,000 .00**

B. Acquisition by gift, donation, or lease.

1.	Facility (Inclusive of Building and Land) (Estimated FMV)	0 .00
2.	Building Only	
3.	Land Only	
4.	Equipment (Specify)	
5.	Other (Specify)	
	Subsection B Total	**0 .00**

C. Financing costs and fees

1.	Interim Financing	0 .00
2.	Underwriting Costs	
3.	Reserve for One Year's Debt Service	
4.	Other (Specify)	
	Subsection C Total	**0 .00**

D.	Estimated Project Cost (A + B + C)		**$ 110,000.00**
E.	CON Filing Fee		**$ 3,000.00**
F.	Total Estimated Project Cost (D + E)	TOTAL	**$ 113,000.00**

2. **Identify the funding sources for this project.**

   a. **Please check the applicable item(s) below and briefly summarize how the project will be financed.** ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)***

___ **A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;**

___ **B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;**

___ **C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.**

___ **D. Grants--Notification of intent form for grant application or notice of grant award; or**

_x_ **E. Cash Reserves--Appropriate documentation from Chief Financial Officer.**

___ **F. Other—Identify and document funding from all other sources.**

Response: The Applicant has space under lease at the present time. This Application includes administrative costs, and a relatively small amount for equipment, only (already purchased), and there is no construction or renovation. The higher of FMV and/or lease costs for the site were approved when the original ASTC was approved. Cash reserves have been utilized to pay for these nominal costs.

3. **Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.**

Response: This Application includes administrative costs, and a relatively small amount for equipment, only (already purchased), and there is no construction or renovation. The higher of FMV and/or lease costs for the site were approved when the original ASTC was approved.

The most recent comparable ASTC approved by the HSDA was the PCET Surgery Center in Knoxville, approved at the May 23, 2012 HSDA meeting. That particular project cost was $1,396,681.

The Surgical and Pain Treatment Center of Clarksville, LLC was denied at the December 12, 2012 meeting of the HSDA, and the project cost of that project was $1,012,993.

Therefore, our project cost is extremely reasonable.

4. **Complete Historical and Projected Data Charts on the following two pages--Do not modify the Charts provided or submit Chart substitutions! Historical Data Chart represents revenue and expense information for the last three (3) years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the Proposal Only (i.e., if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).**

Response: Historical and Projected Data Charts are attached.

Historical Data Chart:

There is not sufficient historical utilization for the Applicant due to the fact interventional pain management services were just starting to be provided for a time, prior to the HSDA reversing that approval.

Projected Data Chart:

This chart includes projected data for interventional pain management procedures for the Applicant. Note that the Applicant anticipates positive cash flow in both years.

Procedures: It is projected that 3,455 and 4,442 interventional pain management procedures will be performed in years 1 and 2, respectively. These projections are based on historical utilization at the Applicant's facility, coupled with anecdotal information retrieved from several doctors in the Nashville area.

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January (month).

2013 AUG 15 PM 2 32

Response:

		Yr-1	Y-2	Yr-3
A.	Utilization/Occupancy Rate (visits)	0	0	0
B.	Revenue from Services to Patients			
	1. Inpatient Services	0	0	0
	2. Outpatient Services	0	0	0
	3. Emergency Services	0	0	0
	4. Other Operating Revenue (Specify) _____	0	0	0
	Gross Operating Revenue	**0**	**0**	**0**
C.	Deductions from Operating Revenue			
	1. Contractual Adjustments	0	0	0
	2. Provision for Charity Care	0	0	0
	3. Provision for Bad Debt	0	0	0
	Total Deductions	**0**	**0**	**0**
	NET OPERATING REVENUE	**0**	**0**	**0**
D.	Operating Expenses	0	0	0
	1. Salaries and Wages	0	0	0
	2. Physician's Salaries and Wages	0	0	0
	3. Supplies	0	0	0
	4 . Taxes	0	0	0
	5 . Depreciation	0	0	0
	6. Rent	0	0	0
	7. Interest, other than Capital	0	0	0
	8. Other Expenses (Specify) _____	0	0	0
	Total Operating Expenses	**0**	**0**	**0**
E.	Other Revenue (Expenses)-Net (Specify)	0	0	0
	NET OPERATING INCOME (LOSS)	**0**	**0**	**0**
F.	Capital Expenditures			
	1. Retirement of Principal	0	0	0
	2. Interest	0	0	0
	Total Capital Expenditure	**0**	**0**	**0**
	NET OPERATING INCOME (LOSS) LESSCAPITAL EXPENDITURES	**0**	**0**	**0**

PROJECTED DATA CHART
(Interventional Pain Management)

Give information for the two (2) years following the completion of this project. The fiscal year begins in January (month).

2013 AUG 15 PM 2:32

		Yr-1	Yr-2
A.	Utilization/Occupancy Rate (*surgical patients)*)	3,455	4,442
B.	Revenue from Services to Patients		
	1. Inpatient Services		
	2. Outpatient Services	4,646,975	5,974,490
	3. Emergency Services		
	4. Other Operating Revenue (Specify) _____		
	Gross Operating Revenue	**4,646,975**	**5,974,490**
C.	Deductions from Operating Revenue		
	1. Contractual Adjustments	3,299,352	4,241,887
	2. Provision for Charity Care	232,348	298,724
	3. Provision for Bad Debt	185,879	238,979
	Total Deductions	**3,717,579**	**4,779,590**
	NET OPERATING REVENUE	**929,396**	**1,194,900**
D.	Operating Expenses		
	1. Salaries and Wages	125,000	128,750
	2. Physician's Salaries and Wages (Medical Director)	337,500	357,750
	3. Supplies	120,000	135,000
	4. Taxes	25,800	38,460
	5. Depreciation	11,316	11,316
	6. Rent	40,380	45,272
	7. Interest, other than Capital		
	8. Management Fees:		
	a. Fees to Affiliates		
	b. Fees to Non-Affiliates		
	9. Other Expenses (Specify) office supplies, advertising, insurance utilities	138,800	138,800
	Total Operating Expenses	**798,796**	**855,348**
E.	Other Revenue (Expenses)-Net (Specify)		
	NET OPERATING INCOME (LOSS)	**130,600**	**339,552**
F.	Capital Expenditures		
	1. Retirement of Principal		
	2. Interest (on Letter of Credit)		
	Total Capital Expenditure		
	NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	**130,600**	**339,552**

PROJECTED DATA CHART
(Total Facility)

Give information for the two (2) years following the completion of this project. The fiscal year begins in January (month).

2013 AUG 15 PM 2:32

		Yr-1	Yr-2
A.	Utilization/Occupancy Rate *(surgical patients))*	3,605	4,627
B.	Revenue from Services to Patients		
	1. Inpatient Services		
	2. Outpatient Services	6,896,975	8,749,490
	3. Emergency Services		
	4. Other Operating Revenue (Specify) _____		
	Gross Operating Revenue	**6,896,975**	**8,749,490**
C.	Deductions from Operating Revenue		
	1. Contractual Adjustments	4,896,852	6,212,137
	2. Provision for Charity Care	356,098	451,349
	3. Provision for Bad Debt	298,379	377,779
	Total Deductions	**5,551,329**	**7,041,265**
	NET OPERATING REVENUE	**1,345,646**	**1,707,865**
D.	Operating Expenses		
	1. Salaries and Wages	125,000	128,750
	2. Physician's Salaries and Wages (Medical Director)	337,500	357,750
	3. Supplies	148,000	169,533
	4. Taxes	25,800	34,5330
	5. Depreciation	11,316	11,316
	6. Rent	39,633	40,380
	7. Interest, other than Capital		
	8. Management Fees:		
	a. Fees to Affiliates		
	b. Fees to Non-Affiliates		
	9. Other Expenses (Specify) office supplies, advertising, insurance, utilities	138,800	138,800
	Total Operating Expenses	**825,249**	**881,062**
E.	Other Revenue (Expenses)-Net (Specify)		
	NET OPERATING INCOME (LOSS)	**520,397**	**826,803**
F.	Capital Expenditures		
	1. Retirement of Principal		
	2. Interest (on Letter of Credit)		
	Total Capital Expenditure		
	NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	**520,397**	**826,803**

5. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

Response: See (rounded) projected figures below for Year 1:

$	1,345	Average Gross Charge per procedure
$	1,076	Average Deduction from Operating Revenue per procedure
$	269	Average Net Charge per procedure.

The above charges are facility charges, only. Clinical professionals, such as chiropractors, medical doctors, doctors of osteopathy, and anesthesiologists, will bill for their own respective services. The Applicant has no control over the billing or participating insurance providers for these clinical professionals.

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

Response: There are no current charges. See (rounded) projected figures below for Year 1:

$	1,345	Average Gross Charge per procedure
$	1,076	Average Deduction from Operating Revenue per procedure
$	269	Average Net Charge per procedure.

The above charges are facility charges, only. Clinical professionals, such as chiropractors, medical doctors, doctors of osteopathy, and anesthesiologists, will bill for their own respective services. The Applicant has no control over the billing or participating insurance providers for these clinical professionals.

Anticipated revenue from the proposed project indicate a positive cash flow for the first two years of operation.

B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response: *Attachment C.N.5.A* is a list of all hospitals in the service area that report performing pain management services. None of these hospitals are exclusively dedicated to pain management.

Attachment C.N.5.B is a list of all ASTCs in the service area that report performing pain management services. Four of these ASTCs appear to be exclusively dedicated to pain management.

The fact that no existing hospitals are dedicated to pain management is not a derogatory statement. It merely points out the fact that the Applicant will not be able to compare our anticipated charges with the charge information from these existing providers. The Joint Annual Reports do not segregate costs/charges by service. See *Attachment C.N.5.C* which shows charge information for the 4 ASTCs which are apparently providing pain management services, only. Please note that the anticipated charges by the Applicant are significantly lower than these 4 ASTCs.

7. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.

Response: The Projected Data Chart indicates sufficient income to maintain cost-effectiveness, with a positive cash flow for both projected years. Obviously, income is dependent upon rendering services to a sufficient number of patients. The Applicant believes such will be the case.

8. Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

Response: The Projected Data Chart indicates sufficient income to maintain cost-effectiveness, with a positive cash flow for both projected years. Obviously, income is dependent upon rendering services to a sufficient number of patients. The Applicant believes such will be the case.

9. **Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.**

Response:

Procedures: It is projected that 3,455 and 4,442 interventional pain management procedures will be performed in years 1 and 2, respectively. These projections are based on historical utilization at the Applicant's facility, coupled with anecdotal information retrieved from several doctors in the Nashville area.

Medicare and TennCare Revenue Projections: Based on the patients seen by the Applicant when interventional pain management services were being provided, we anticipate the following patients:

Medicare	40%
Medicaid	10%
Commercial	45%
Private Pay	5%

Based on these projections, it is anticipated that the impact on Medicare will be as follows:

$4,646,975 x 40% = $1,858,790.

Likewise, it is anticipated that the impact on Medicaid will be as follows:

$4,646,975 x 10% x 30% State Share = $139,410.

10. **Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.**

Response: Please see *Attachment C.EF.10.*

11. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

a. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

Response: There were no other viable alternatives considered.

As stated earlier, the Applicant was approved to provide MUA services. When we began the procedures, we were advised by the insurers that we had to attempt interventional pain management procedures first, or we would not be compensated for the traditional MUA procedure. We felt that interventional pain management procedures were a part of MUA, and requested a determination from the HSDA to that extent. We were approved by the HSDA to perform these procedures, and we did so. Later, the HSDA decided we could not perform such procedures and we had to cease providing them. Since we cannot be compensated for what we have already been approved for, we had to submit this application.

b. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

Response: There were no other viable alternatives considered.

As stated earlier, the Applicant was approved to provide MUA services. When we began the procedures, we were advised by the insurers that we had to attempt interventional pain management procedures first, or we would not be compensated for the traditional MUA procedure. We felt that interventional pain management procedures were a part of MUA, and requested a determination from the HSDA to that extent. We were approved by the HSDA to perform these procedures, and we did so. Later, the HSDA decided we could not perform such procedures and we had to cease providing them. Since we cannot be compensated for what we have already been approved for, we had to submit this application.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. **List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.**

Response: The Applicant has a contractual relationship with St. Thomas Hospital. Please see *Attachment C.OD.1.*

2. **Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.**

Response: The approval of this application should not have a material adverse impact on any health care providers in the State. There are no facilities in our service area that are dedicated to the provision of both interventional pain management and MUA procedures.

To our knowledge (based on JARs) we are not aware of any hospitals who provide interventional pain management services exclusively, and cannot compare our data to the JARs. There are 4 ASTCs that appear to limit their respective services to interventional pain management services, but those facilities operated at 2,289 procedures per room in 2012 (Attachment C.N.5.B lists all ASTCs that provide pain management services, and the 2012 data for these 4 ASTCs show that 25,171 procedures were performed in 11 procedure rooms). Since these facilities are operating well above the Guidelines, there should be no material adverse impact on these facilities when our application is approved.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.

Response: According to the Tennessee Department of Labor and Workforce Development, there are no published reports available indicating the personnel positions required for the operation of a specialty ASTC. As the publishing of such information might be considered a violation of Anti-Trust, existing ASTCs cannot get together and decide on what salaries to pay for these positions. It should be assumed that existing salaries will be commensurate with both abilities and the marketplace, and the Applicant will maintain that staff. *Attachment C.OD.3* contains affiliated health care workers data.

Existing staff at the Applicant's ASTC will be utilized for this service, and no new staff will be required.

The Applicant works with area training programs to allow students to rotate though our facility to complete clinical training requirements. Further, doctors have been trained in the ASTC.

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

Response: According to the Tennessee Department of Labor and Workforce Development, there are no published reports available indicating the personnel positions required for the operation of a specialty ASTC. As the publishing of such information might be considered a violation of Anti-Trust, existing ASTCs cannot get together and decide on what salaries to pay for these positions. It should be assumed that existing salaries will be commensurate with both abilities and the marketplace, and the Applicant will maintain that staff. *Attachment C.OD.3* contains affiliated health care workers data.

Existing staff at the Applicant's ASTC will be utilized for this service, and no new staff will be required.

The Applicant works with area training programs to allow students to rotate though our facility to complete clinical training requirements. Further, doctors are trained in the ASTC.

5. **Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review** ***policies and programs, record keeping, and staff education.***

Response: The Applicant is familiar with licensing certification requirements for an ASTC, as the facility is already licensed.

6. **Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (*e.g.*, internships, residencies, etc.).**

Response: The Applicant works with area training programs to allow students to rotate though our facility to complete clinical training requirements. Further, doctors have been trained in the ASTC.

7. **(a) Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.**

Response: The Applicant is familiar with licensing certification requirements for an ASTC, as the facility is already licensed.

(b) Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Response:

Licensure: Tennessee Department of Health.

Accreditation: Medicaid, Medicare, TennCare, AAAHC.

(c) If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.

Response: The ASTC is licensed. Please see Attachment C.OD.7(c).

(d) For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.

Response: Please see Attachment C.OD.7(d), which includes both TDOH Licensure survey and AAAHC survey information.

8. **Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.**

Response: There have been no final orders or judgments as are contemplated by this question.

9. **Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project**

Response: There have been no final orders or judgments as are contemplated by this question.

10. **If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.**

Response: The Applicant will provide all data contemplated by this question.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

Response: Please see attached tear sheet from *The Tennessean.*

DEVELOPMENT SCHEDULE

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**
2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph,* please state below any request for an extended schedule and document the "good cause" for such an extension.**

Form HF0004
Revised 05/03/04
Previous Forms are obsolete

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in Rule 68-11-1609(c): 12/2010.

2013 AUG 15 PM 2 32

Assuming the CON approval becomes the final agency action on that date; indicate the number of day **from the above agency decision date** to each phase of the completion forecast.

Phase	**DAYS REQUIRED**	**Anticipated Date (MONTH/YEAR)**
1. Architectural and engineering contract signed		
2. Construction documents approved by the Tennessee Department of Health		
3. Construction contract signed		
4. Building permit secured		
5. Site preparation completed		
6. Building construction commenced		
7. Construction 40% complete		
8. Construction 80% complete		
9. Construction 100% complete (approved for occupancy (renovation)		
10. *Issuance of license	60	02/2014
11. *Initiation of service	60	02/2014
12. Final Architectural Certification of Payment		
13. Final Project Report Form (HF0055)		

*** For projects that do NOT involve construction or renovation : Please complete items 10 and 11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

AFFIDAVIT

2013 AUG 15 PM 2 32

STATE OF TENNESSEE

COUNTY OF DAVIDSON

E. Graham Baker, Jr., being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete to the best of his/her knowledge.

E. Graham Baker, Jr. /Attorney
SIGNATURE/TITLE

Sworn to and subscribed before me this 15th day of August, 2013, a
(month) (year)

Notary Public in and for the County/State of Davidson/Tennessee.

Nadean E. Poteet
NOTARY PUBLIC

NADEAN E. POTEET
STATE OF TENNESSEE
NOTARY PUBLIC
DAVIDSON COUNTY

My commission expires July 3rd, 2017.
(Month/Day) (Year)

STATE OF TENNESSEE

STATE HEALTH PLAN

CERTIFICATE OF NEED STANDARDS AND CRITERIA

FOR

AMBULATORY SURGICAL TREATMENT CENTERS

Determination of Need

1. Need. **The minimum numbers of 884 Cases per Operating Room and 1867 Cases per Procedure Room are to be considered as baseline numbers for purposes of determining Need. An applicant should demonstrate the ability to perform a minimum of 884 Cases per Operating Room and/or 1867 Cases per Procedure Room per year, except that an applicant may provide information on its projected case types and its assumptions of estimated average time and clean up and preparation time per Case if this information differs significantly from the above-stated assumptions. It is recognized that an ASTC may provide a variety of services/Cases and that as a result the estimated average time and clean up and preparation time for such services/Cases may not meet the minimum numbers set forth herein. It is also recognized that an applicant applying for an ASTC Operating Room(s) may apply for a Procedure Room, although the anticipated utilization of that Procedure Room may not meet the base guidelines contained here. Specific reasoning and explanation for the inclusion in a CON application of such a Procedure Room must be provided. An applicant that desires to limit its Cases to a specific type or types should apply for a Specialty ASTC.**

Response:

Procedures: It is projected that 3,455 and 4,442 interventional pain management procedures will be performed in years 1 and 2, respectively. These projections are based on historical utilization at the Applicant's facility, coupled with anecdotal information retrieved from several doctors in the Nashville area.

2. Need and Economic Efficiencies. **An applicant must estimate the projected surgical hours to be utilized per year for two years based on the types of surgeries to be performed, including the preparation time between surgeries. Detailed support for estimates must be provided.**

Response:

Procedures: It is projected that 3,455 and 4,442 interventional pain management procedures will be performed in years 1 and 2, respectively. These projections are based on historical utilization at the Applicant's facility, coupled with anecdotal information retrieved from several doctors in the Nashville area.

The ASTC will be available Monday through Friday, 8 hours per day. This means that the ASTC will be available 120,000 minutes per year (5 days x 8 hours x 60 minutes x 50 weeks), meaning that in Year 1, 34 minutes will be available for each procedure, and in Year 2, about 27 minutes will be available for each procedure. Since each procedure will take less than 15 minutes, sufficient time will be available.

3. **Need; Economic Efficiencies; Access. To determine current utilization and need, an applicant should take into account both the availability and utilization of either: a) all existing outpatient Operating Rooms and Procedure Rooms in a Service Area, including physician office based surgery rooms (when those data are officially reported and available) OR b) all existing comparable outpatient Operating Rooms and Procedure Rooms based on the type of Cases to be performed. Additionally, applications should provide similar information on the availability of nearby out-of-state existing outpatient Operating Rooms and Procedure Rooms, if that data are available, and provide the source of that data. Unstaffed dedicated outpatient Operating Rooms and unstaffed dedicated outpatient Procedure Rooms are considered available for ambulatory surgery and are to be included in the inventory and in the measure of capacity.**

Response:

Attachment C.N.5.A is a list of all hospitals in the service area that report performing pain management services. None of these hospitals are exclusively dedicated to pain management.

Attachment C.N.5.B is a list of all ASTCs in the service area that report performing pain management services. Four of these ASTCs appear to be exclusively dedicated to pain management.

The fact that no existing hospitals are dedicated to pain management is not a derogatory statement. It merely points out the fact that the Applicant will not be able to compare our anticipated charges with the charge information from these existing providers. The Joint Annual Reports do not segregate costs/charges by service. See *Attachment C.N.5.C* which shows charge information for the 4 ASTCs which are apparently providing pain management services, only. Please note that the anticipated charges by the Applicant are significantly lower than these 4 ASTCs.

The approval of this application should not have a material adverse impact on any health care providers in the State. There are no facilities in our service area that are dedicated to the provision of both interventional pain management and MUA procedures.

To our knowledge (based on JARs) we are not aware of any hospitals who provide interventional pain management services exclusively, and cannot compare our data to the JARs. There are 4 ASTCs that appear to limit their respective services to interventional pain management services, but those facilities operated at 2,289 procedures per room in 2012 (Attachment C.N.5.B lists all ASTCs that provide pain management services, and the 2012 data for these 4 ASTCs show that 25,171 procedures were performed in 11 procedure rooms). Since these facilities are operating well above the Guidelines, there should be no material adverse impact on these facilities when our application is approved.

4. **Need and Economic Efficiencies. An applicant must document the potential impact that the proposed new ASTC would have upon the existing service providers and their**

referral patterns. A CON application to establish an ASTC or to expand existing services of an ASTC should not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed, if those services are known and relevant, within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above.

Response:

Attachment C.N.5.A is a list of all hospitals in the service area that report performing pain management services. None of these hospitals are exclusively dedicated to pain management.

Attachment C.N.5.B is a list of all ASTCs in the service area that report performing pain management services. Four of these ASTCs appear to be exclusively dedicated to pain management.

The fact that no existing hospitals are dedicated to pain management is not a derogatory statement. It merely points out the fact that the Applicant will not be able to compare our anticipated charges with the charge information from these existing providers. The Joint Annual Reports do not segregate costs/charges by service. See *Attachment C.N.5.C* which shows charge information for the 4 ASTCs which are apparently providing pain management services, only. Please note that the anticipated charges by the Applicant are significantly lower than these 4 ASTCs.

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5. **<u>Need and Economic Efficiencies</u>. An application for a Specialty ASTC should present its projections for the total number of cases based on its own calculations for the projected length of time per type of case, and shall provide any local, regional, or national data in support of its methodology. An applicant for a Specialty ASTC should provide its own definitions of the surgeries and/or procedures that will be performed and whether the Surgical Cases will be performed in an Operating Room or a Procedure Room. An applicant for a Specialty ASTC must document the potential impact that the proposed new ASTC would have upon the existing service providers and their referral patterns. A CON proposal to establish a Specialty ASTC or to expand existing services of a Specialty ASTC shall not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above. An applicant that is granted a CON for a Specialty ASTC shall have the specialty or limitation placed on the CON.**

Response:

Procedures: It is projected that 3,455 and 4,442 interventional pain management procedures will be performed in years 1 and 2, respectively. These projections are based on historical utilization at the Applicant's facility, coupled with anecdotal information retrieved from several doctors in the Nashville area.

The ASTC will be available Monday through Friday, 8 hours per day. This means that the ASTC will be available 120,000 minutes per year (5 days x 8 hours x 60 minutes x 50 weeks), meaning that in Year 1, 34 minutes will be available for each procedure, and in Year 2, about 27 minutes will be available for each procedure. Since each procedure will take less than 15 minutes, sufficient time will be available.

Other Standards and Criteria

6. **Access to ASTCs. The majority of the population in a Service Area should reside within 60 minutes average driving time to the facility.**

Response:

The majority of patients in the service area will reside within 60 minutes average driving time to our facility.

7. **Access to ASTCs. An applicant should provide information regarding the relationship of an existing or proposed ASTC site to public transportation routes if that information is available.**

Response:

Buses run on White Bridge Road, West End Avenue, and Charlotte Pike, and private taxis are also available. As the site of the proposed facility is on White Bridge Road, the site is readily accessible for patients.

8. **Access to ASTCs. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project the origin of potential patients by percentage and county of residence and, if such data are readily available, by zip code, and must note where they are currently being served. Demographics of the Service Area should be included, including the anticipated provision of services to out-of-state patients, as well as the identity of other service providers both in and out of state and the source of out-of-state data. Applicants shall document all other provider alternatives available in the Service Area. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.**

Response:

The Applicant's service area consists of Davidson, Williamson, Rutherford and Robertson Counties (patient origin of 98% of the patients of Tennessee Spine and Nerve Institute, Inc., in 2009, in order by county).

9. **Access and Economic Efficiencies. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment**

center must project patient utilization for each of the first eight quarters following completion of the project. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.

Response:

It is anticipated that utilization will be as follows:

1st Quarter	863 procedures
2nd Quarter	864 procedures
3rd Quarter	864 procedures
4th Quarter	864 procedures
5th Quarter	1,110 procedures
6th Quarter	1,110 procedures
7th Quarter	1,111 procedures
8th Quarter	1,111 procedures

10. **Patient Safety and Quality of Care; Health Care Workforce.**

    a. **An applicant should be or agree to become accredited by any accrediting organization approved by the Centers for Medicare and Medicaid Services, such as the Joint Commission, the Accreditation Association of Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgical Facilities, or other nationally recognized accrediting organization.**

    b. **An applicant should estimate the number of physicians by specialty that are expected to utilize the facility and the criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel. An applicant should provide documentation on the availability of appropriate and qualified staff that will provide ancillary support services, whether on- or off-site.**

Response:

The Applicant is licensed by the TDOH, is certified by both Medicare and Medicaid, and is accredited by AAAHC.

To date, at least 4 physicians have utilized our ASTC.

11. **Access to ASTCs. In light of Rule 0720-11.01, which lists the factors concerning need on which an application may be evaluated, and Principle No. 2 in the State Health Plan, "Every citizen should have reasonable access to health care," the HSDA may decide to give special consideration to an applicant:**

    a. **Who is offering the service in a medically underserved area as designated by the United States Health Resources and Services Administration;**

    b. **Who is a "safety net hospital" or a "children's hospital" as defined by the Bureau of TennCare Essential Access Hospital payment program;**

    c. **Who provides a written commitment of intention to contract with at least one TennCare MCO and, if providing adult services, to participate in the Medicare program; or**

d. Who is proposing to use the ASTC for patients that typically require longer preparation and scanning times. The applicant shall provide in its application information supporting the additional time required per Case and the impact on the need standard.

Response:

The Applicant agrees that every citizen should have reasonable access to health care. When we opened our ASTC, patients started coming to our facility. Unfortunately, we were forced to shut it back down due to a change by the HSDA. We contract with:

BLUECARE
AMERIGROUP
TENNCARE SELECT
BLUE ADVANTAGE
SECURE HORIZON
HUMANA GOLD CHOICE/EMERALD PLAN/DIAMOND PLAN
HEALTHSPRING MEDICARE ADVANTAGE PLAN
HEALTHSPRING COVENTRY
WINDSOR / MEDICARE EXTRA
GOLDEN RULE
UNITED MEDICAL RESOURCES
HERITAGE SELECT
STERLING OPTIONS I & II
MEDICARE COMPLETE
PYRAMID LIFE INSURANCE COMPANY
SEDGWICK
TODAY'S OPTIONS
UHC PLAN OF RIVER VALLEY
MEDICARE RAILROAD (RETIREMENT BOARD) FOR RAILROAD EMPLOYEES
DME CONTRACTORS FOR MEDICARE:
NATIONAL GOVERNMENT SERVICES: FOR REGION B
NORIDIAN FOR REGION D AND REGION A

Attachment A.4

Business Entity Detail

Entity details cannot be edited. This detail reflects the current state of the filing in the system.

Return to the Business Information Search.

Actions Available For This Entity:

File Annual Report | Update Mailing Address
Certificate of Existence | Change Registered Agent

000640122: Limited Liability Company - Domestic

Printer Friendly Version

Name: MUA of Middle Tennessee, LLC

Status: Active
Formed in: TENNESSEE
Fiscal Year Close: December
Term of Duration: Perpetual
Principal Office: 28 WHITE BRIDGE RD
STE 210
NASHVILLE, TN 37205-1467 USA
Mailing Address: 28 WHITE BRIDGE RD
STE 210
NASHVILLE, TN 37205-1467 USA
AR Exempt: No
Managed By: Member Managed

Initial Filing Date: 09/15/2010
Delayed Effective Date:
AR Due Date: 04/01/2014
Inactive Date:
Obligated Member Entity: No
Number of Members: 4

Assumed Names | History | Registered Agent

Name	Status	Expires
No Assumed Names Found...		

Division of Business Services
312 Rosa L. Parks Avenue, Snodgrass Tower, 6th Floor
Nashville, TN 37243
615-741-2286
Email | Directions | Hours and Holidays

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

Filing Information

Name: **MUA of Middle Tennessee, LLC**

General Information

SOS Control # :	**640122**	Formation Locale:	TENNESSEE
Filing Type:	Limited Liability Company - Domestic	Date Formed:	09/15/2010
Filing Date:	09/15/2010 1:10 PM	Fiscal Year Close	12
Status:	Active	Member Count:	4
Duration Term:	Perpetual		
Managed By:	Member Managed		

Registered Agent Address
TERRY TOTTY, D.C.
STE 210
28 WHITE BRIDGE RD
NASHVILLE, TN 37205-1467

Principal Address
STE 210
28 WHITE BRIDGE RD
NASHVILLE, TN 37205-1467

The following document(s) was/were filed in this office on the date(s) indicated below:

Date Filed	Filing Description	Image #
03/19/2013	2012 Annual Report	7170-0416
	Principal Address 1 Changed From: 28 WHITE BRIDGE ROAD To: 28 WHITE BRIDGE RD	
	Principal Address 2 Changed From: # 210 To: STE 210	
	Principal Postal Code Changed From: 37205 To: 37205-1467	
	Member Count Changed From: 3 To: 4	
01/09/2012	2011 Annual Report	6980-0592
	Member Count Changed From: 2 To: 3	
01/11/2011	2010 Annual Report	A0053-0317
	Principal County Changed From: No value To: Davidsom	
	Member Count Changed From: 1 To: 2	
09/15/2010	Initial Filing	6770-0319

Active Assumed Names (if any)	Date	Expires

THE STATE OF TENNESSEE

COUNTY OF DAVIDSON

LESSOR

THIS LEASE AGREEMENT made and entered into on this 1st day of September 2009, between NOL, LLC a Tennessee Limited Liability Corporation, (hereinafter called "Lessor") whose address for purposes hereof is 28 White Bridge Road, Nashville, TN 37205;

-and-

LESSEE

Tennessee Spine and Nerve Institute, Inc., a Tennessee Corporation, (hereinafter called "Lessee") whose address for purposes hereof is 28 White Bridge Road, Suite 208, Nashville, TN 37205 and thereafter being that of the "Building" (hereinafter defined).

WITNESSETH:

LEASED PREMISES

1. Subject to and upon the terms, provisions and conditions hereinafter set forth, and each in consideration of the duties, covenants and obligations of the other hereunder, Lessor does hereby lease, demise and let to Lessee and Lessee does hereby lease from Lessor those certain premises (hereinafter sometimes called the "leased premises") in the building known as the Anderson Building (herein called the "Building") located at 28 White Bridge Road, Nashville, Tennessee 37205, such premises being more particularly described as follows:

5,383.08 Square Feet on the Second Floor, Suite #208

The term "Net Rentable Area" (NRA), as used herein, shall refer to:

(A) in the case of a single tenancy floor, all floor area measured from the inside surface of the outer glass or finished column or exterior wall of the Building (whichever surface represents the farthest distance from the surface of any opposite exterior or interior wall, excluding only the areas ("Service Areas") within the exterior walls used for elevator mechanical rooms, building stairs, fire towers, refuse disposal shaft, elevator shafts, flues, vents, stacks, pipe shafts and vertical ducts, but including any "Service Areas" which are for the specific use of the particular tenant such as special stairs, elevators and hallways-lobbies.

(B) In the case of a partial floor, all floor areas within the inside surface of the outer glass or finished column or exterior walls enclosing the portion of the Lease Premises on such floor and measured to the mid-point of the walls separating areas leased by or held for lease to other tenants or from areas devoted to corridors, elevator foyers, rest rooms, mechanical rooms, janitor closets, refuse disposal shafts, elevator shafts, flues, vents, stacks, pipe shafts and vertical ducts on a particular floor (hereinafter sometimes called "Common Areas"), but including a proportionate part of the "Common Areas" located on such floor based upon the ratio which the Tenant's NRA on such floor (determined by excluding such "Common Areas") bears to the aggregate NRA on such floor (determined by excluding such "Common Areas"). No deductions from NRA are made for columns or projections necessary to the Building. The NRA in the leased premises has been calculated on the basis of the foregoing definition and is hereby stipulated for all purposes hereof to be 5,383.08 square feet for suite 208, whether the same should be more or less as a result of minor variations resulting from actual construction and completion of the leased premises for occupancy so long as such work is done in accordance with the terms and provisions hereof.

II.

TERM

1. Subject to and upon the terms and conditions set forth herein, or in any exhibit or addendum hereto, this lease shall continue in force for a term of Eighty-Four (84) months, beginning on the First day of September, 2009, and ending on the Thirty-First day of August, 2016.

USE

2. The Leased Premises are to be used and occupied by Lessee solely for the purpose of office space, chiropractic, and medical services.

BASE RENTAL

3. Lessee hereby agrees to pay a base annual rental (herein called "Base Rental") as shown on EXHIBIT A. The Lessee shall also pay, as additional rent, all such other sums of money as shall become due from and payable by Lessee to Lessor under this Lease. The Lessor shall have the same remedies for default for the payment of additional rent as are available to Lessor in the case of a default in the payment of Base Rental. Such Base Rental, together with any adjustment of rent provided for herein, then in effect shall be due and payable in twelve (12) equal installments on the first day of each calendar month during the initial term of this Lease and any extensions or renewals thereof, and Lessee hereby agrees to so pay such rent to Lessor at Lessor's address as provided herein (or such other address as may be designated by Lessor from time to time) monthly, in advance, without demand. If the terms of this Lease Agreement as heretofore established commences on other than the first day of a month, or terminates on other than the last day of a month, then the installments of Base Rental for such month or months shall be prorated and the installments so prorated shall be paid in advance. All past due installments of rent shall bear interest at the maximum lawful rate per annum until paid.

BASE RENTAL ADJUSTMENT

4. The Base Rental Adjustment shall be calculated and paid in accordance with the following:

(a) Lessee's Base Rental includes a component applicable to Basic Costs (hereinafter defined) equal to the Basic Costs per square foot of Net Rentable Area for the calendar year 2008. Net Rental Area for these purposes will be 5,383.08 square feet. Basic Costs are an estimate as if the Building were in operation on the date Lessee received Lessor's proposal.

(b) Prior to the commencement of each calendar year of Lessee's occupancy, Lessor shall provide an estimate in reasonable detail of Basic Costs for said calendar year. Lessee shall pay a base Rental for said calendar year adjusted upward or downward, as appropriate, by the amount of difference between the prior calendar year's estimated Basic Costs per square foot and the coming year's estimated Basic Costs per square foot.

(c) Within 150 days or as soon thereafter as possible of the conclusion of which calendar year of the lease term, Lessor shall furnish to Lessee an audited statement in reasonable detail of Lessor's Basic Cost for said lease year. A lump sum payment will be made from Lessor to Lessee or from Lessee to Lessor, as appropriate, within 30 days of the delivery of such audited statement equal to the product of the square footage in the Leased Premises and the difference in actual Basic Costs per square foot and estimated Basic Costs per square foot. The effect of this reconciliation payment is that Lessee will pay during the lease term its share of Basic Cost increases over the original Basic Costs per square foot of Net Rentable Area for the calendar year 2008.

Nothing contained in this Paragraph 4 shall be construed at any time so to reduce the monthly installments of Base Rental payable hereunder below the amount set forth in Article II, Paragraph 3 of this Lease Agreement.

5. "Basic Costs" as said term is used herein shall consist of all operating expenses of the Building, which shall be computed on the accrual basis and shall consist of all expenditures by Lessor to maintain all facilities in operation at the beginning of the Lease Term and such additional facilities in subsequent years as may be determined by Lessor to be necessary and beneficial for the operations of the Building. All operating expenses shall be determined in accordance with generally accepted accounting principles which shall be consistently applied. The term "operating expenses" as used herein shall mean all reasonable expenses, costs, and disbursements (but not replacement of capital investment items nor specific costs, especially billed to and paid by specific tenants, nor broker commissions) of every kind and nature which Lessor shall pay or become obligated to pay because of or in connection with the ownership and operation of the Building, including but not limited to, the following:

(a) Wages and salaries of all employees engaged in operating and maintenance or security of the Building and of personnel who may provide traffic control relating to ingress and egress between the Parking Garage and adjacent public streets. All taxes, insurance and benefits relating to employees providing these services shall be included.

(b) All supplies and materials used in operation and maintenance of the Building.

(c) Cost of all utilities for the Building, including the cost of water and power, heating, lighting, air conditioning and ventilating for the Building.

(d) Cost of all maintenance, janitorial, and service agreements for the Building (including the lawns appurtenant to the Building and the drive in front of the Building) and the equipment therein, including alarm service, window cleaning and elevator maintenance.

(e) Cost of all insurance relating to the Building, including the cost of casualty and liability insurance applicable to the Building and Lessor's personal property and used in connection therewith.

(f) All taxes and assessments and governmental charges whether federal, state, county or municipal, and whether they be by taxing districts or authorities presently taxing the leased premises or by others, subsequently created or otherwise, and any other taxes and assessments attributable to the Building or its operation (including the lawns appurtenant to the Building and the drive in front of the Building). It is agreed that Lessee will be responsible for ad valorem taxes on its personal property and on the value of lease hold improvements to the extent that same exceed standard building allowances.

(g) Cost of repairs and general maintenance (excluding repairs and general maintenance paid by proceeds of insurance or by Lessee or other third parties, and alterations attributable solely to tenants of the Building other than Lessee).

(h) Amortization of the cost of installation of capital investment items which are primarily for the purpose of reducing operating costs or which may be required by governmental authority. All such costs shall be amortized over the reasonable life of the capital investment items by an additional charge to be added to rent and paid by Lessee as Additional Rent, with the reasonable life and amortization schedule being determined in accordance with generally accepted accounting principles and in no event to extend beyond the reasonable life of the Building.

(i) Lessor's central accounting costs applicable to the Building.

Notwithstanding any other provision herein to the contrary, it is agreed that in the event the Building is not fully occupied during any year of the lease term, an adjustment shall be made in computing Lessee's share of the Basic Costs for such year so that the Basic Costs shall be computed for such year as though the Building had been fully occupied during such year.

Lessee, at its expense, shall have the right at all reasonable times to audit Lessor's books and records relating to this lease for any year or years for which additional rental payments become due; or at Lessor's sole discretion, Lessor will provide such audit prepared by a certified public accountant.

III.

LESSOR COVENANTS AND AGREES WITH LESSEE:

SERVICES FURNISHED BY LESSOR

1. To cause public utilities to furnish the electricity, gas and water utilized in operating any and all facilities serving the Leased Premises.

2. To provide (as part of the Basic Cost of the Building) entry to the Building during the weekends and after normal working hours during the week. Lessor shall not be liable to Lessee for losses due to theft or burglary, or for damages done by unauthorized persons on the premises.

3. To furnish (as part of the Basic Costs of the Building), Lessee while occupying the premises:

(a) Hot and cold water at those points of supply provided for general use of other tenants in the Building; central heat and air conditioning in season, at such temperatures and in such amounts as are considered by Lessor to be standard, but service at times during week days other than normal business hours for the Building, on Saturday afternoons, Sundays and Holidays to be furnished only upon the request of Lessee, who shall bear the entire cost thereof; routine maintenance and electric lighting service for all public areas and special service areas of the Building in the manner and to the extent deemed by Lessor to be standard.

(b) Electrical facilities to furnish sufficient power for typewriters, voice writers, calculating machines and other machines of similar low electric consumption; but not including electricity required for duplicating and electronic data processing equipment, special lighting in excess of building standard, and any other item of electrical equipment which singly consumes more than 0.5 kilowatts at rated capacity or requires a voltage other than 120 volts, single phase.

(c) Basic janitorial services fives times per week. Failure by Lessor to any extent to furnish the defined services in Paragraphs 1, 2 and 3 of this Article III, or any cessation thereof resulting from causes beyond the reasonable control of Lessor shall not render Lessor liable in any respect for damages to either person or property, nor be construed as an eviction of Lessee, nor work an abatement of rent, nor relieve Lessee from fulfillment of any covenant or agreement hereof. Should any of the equipment or machinery break down, or for any cause cease to function properly, Lessee shall have no claim for rebate of rent or damages on account of an interruption in service occasioned thereby or resulting therefrom. Landlord will repair with due diligence.

KEYS AND LOCKS

4. To furnish Lessee two (2) keys for each corridor door entering the Leased Premises. Additional keys will be furnished at a charge by Lessor on an order signed by Lessee or Lessee's authorized representative. All such keys shall remain the property of Lessor. No additional locks shall be allowed on any door of the Leased Premises without the Lessor's permission, and Lessee shall not make, or permit to be made, any duplicate keys, except those furnished by Lessor. Upon termination of this lease, Lessee shall surrender to Lessor all keys of the Leased Premises, and give to Lessor an explanation of the combination of all locks for safes, safe cabinets and vault doors, if any, in the Leased Premises.

GRAPHICS

5. To provide and install, at Lessee's cost, all letters or numerals on doors in the Leased Premises. All such letters and numerals shall be in the Building standard graphics, and no others shall be used or permitted on the Leased Premises. Lessee's Logo may be used for suite identification so long as the building's standard signage format is used.

PEACEFUL ENJOYMENT

6. That Lessee shall, and may peacefully have, hold and enjoy the Leased Premises, subject to the other terms hereof, provided that Lessee pays the rental and other sums herein recited to be paid by Lessee and performs all of Lessee's covenants and agreements herein contained. It is understood and agreed that this covenant and any and all other covenants of Lessor contained in the lease shall be binding upon Lessor and its successors only with respect to breaches occurring during its and their respective ownership of the Lessor's interest hereunder.

LIMITATION OF LESSOR'S PERSONAL LIABILITY

7. Lessee specifically agrees to look solely to Lessor's interest in the Building for the recovery of any judgment from Lessor, it being agreed that Lessor shall never be personally liable for any such judgment. The provision contained in the foregoing sentence is not intended to, and shall not, limit any right that Lessee might otherwise have to obtain injunctive relief against Lessor or Lessor's successors in interest or any other action not involving the personal liability of Lessor to respond in monetary damages from assets other than Lessor's interest in the Building or any suit or action in connection with enforcement or collection of amounts which may become owing or payable under or on account of insurance maintained by Lessor.

PARKING

8. Lessee shall at all times during the term of this lease have the right to park automobiles in fourteen (14) spaces located in the outdoor parking area of the Building designated by Lessor. Lessee shall have the right to park automobiles in three (3) indoor parking spaces of the indoor parking area of the Building, but will be charged for only two (2) spaces, at a rate of Thirty-five and no/100 dollars ($35.00) per space per month or such other amount as may be established by the Lessor from time to time, subject to availability.

IV.

LESSEE COVENANTS AND AGREES WITH LESSOR:

PAYMENTS BY LESSEE

1. To pay all rent and sums provided to be paid to Lessor hereunder at the times and in the manner herein provided.

REPAIRS BY LESSOR

2. Unless otherwise stipulated herein, Lessor shall not be required to make any improvements to or repairs of any kind or character on the Leased Premises during the term of this lease, except such repairs as may be deemed necessary by Lessor for normal maintenance operations, to include: roof, structural, electrical, HVAC, plumbing, glass, and common areas. The obligations of Lessor to maintain and repair the Leased Premises shall be limited to Building standard items. Special leasehold improvements will, at Lessee's written request, be maintained by Lessor at Lessee's expense, at a cost or charge equal to the costs incurred in such maintenance plus an additional charge to cover overhead.

REPAIRS BY LESSEE

3. At its own cost and expense, to repair or replace any damage or injury done to the Building, or any part thereof, caused by Lessee or Lessee's agents, employees, invitees, or visitors; provided, however, if Lessee fails to make such repairs or replacement promptly, Lessor may, at its option, make repairs or replacement, and Lessee shall repay the cost thereof to the Lessor on demand, subject to Article V, Paragraph 15. Lessor shall have sole authority to approve plans for such repairs if the cost of such repairs exceeds $3,000.00.

CARE OF THE LEASED PREMISES

4. Not to commit or allow any waste or damage to be committed on any portion of the Leased Premises, and at the termination of this Lease, by lapse of time or otherwise, to deliver up said Leased Premises to Lessor in as good condition as at date of possession by Lessee, ordinary wear and tear excepted,

and upon such termination of this Lease, Lessor shall have the right to re-enter and resume possession of the Leased Premises.

ASSIGNMENT OR SUB-LEASE

5. In the event Lessee should desire to assign this Agreement or sublet the Leased Premises or any part thereof, Lessee shall give Lessor written notice of such desire at least sixty (60) days in advance of the date on which Lessee desires to make such assignment or sublease. Lessor shall then have a period of thirty (30) days following receipt of such notice within which to notify Lessee in writing that Lessor elects either (1) to terminate this Agreement as to the space so affected as of the date so specified by Lessee in which event Lessee will be relieved of all further obligation hereunder as to such space, or (2) to permit Lessee to assign or sublet such space, subject, however, to subsequent written approval (consent shall not be unreasonably withheld) of the proposed assignee or sub-lessee by Lessor, or (3) to refuse, in Lessor's sole and absolute discretion, to consent to Lessee's assignment or subleasing such space and to continue this Lease in full force and effect as to the entire Leased Premises. If Lessor should fail to notify Lessee in writing of such election within said (30) day period, Lessor shall be deemed to have elected option (2) above. If Lessor elects to exercise option (2) above, Lessee agrees to provide, at its expense, direct access from the assignment or subleased space to a public corridor of the Building. No assignment or subletting by Lessee shall relieve Lessee of any obligation under this Lease. Any attempted assignment or sublease by Lessee in violation of the terms and covenants of this paragraph shall be void.

ALTERATIONS, ADDITIONS, IMPROVEMENTS

6. Not to permit the Leased Premises to be used for any purpose other than that stated in the use clause hereof, or make or allow to be made any alterations or physical additions in or to the Leased Premises which are visible from outside the Leased Premises, without first obtaining the written consent of Lessor. Any and all such alterations, physical additions, or improvements, when made to the Leased Premises by Lessee, shall at once become the property of Lessor and shall be surrendered to Lessor upon termination of this Lease by lapse of time or otherwise; provided, however, this clause shall not apply to movable equipment or furniture owned by Lessee. Lessee agrees not to permit any portable heaters to be used in the Leased Premises. Lessee agrees that no food, soft drink or other vending machine will be installed within the Leased Premises without the prior written consent of Lessor.

LEGAL USE AND VIOLATIONS OF INSURANCE COVERAGE

7. Not to occupy or use, or permit any portion of the Leased Premises to be occupied or used for any business or purpose which is unlawful, disreputable or deemed to be extra hazardous on account of fire, or permit anything to be done which would in any way increase the rate of fire or liability or any other insurance coverage on said Building and/or its contents.

LAWS AND REGULATIONS; RULES OF BUILDING

8. To comply with all laws, ordinances, rules and regulations (State, Federal, Municipal and other agencies or bodies having any jurisdiction thereof) relating to the use, condition or occupancy of the Leased Premises. Lessee will comply with the rules of the Building adopted and altered by Lessor from time to time for the safety, care and cleanliness of the Leased Premises and Building and for preservation of good order therein, all of which will be sent by Lessor to Lessee in writing and shall be thereafter carried out and observed by Lessee.

ENTRY FOR REPAIRS AND INSPECTION

9. To permit Lessor or its agents or representatives to enter into and upon any part of the Leased Premises at all reasonable hours to inspect the same, clean or make repairs, alterations or additions thereto, as Lessor may deem necessary or desirable, and Lessee shall not be entitled to any abatement or reduction of rent by reason thereof.

NUISANCE

10. To conduct its business and control its agents, employees, invitees, and visitors in such manner as not to create any nuisance, or interfere with, annoy or disturb any other tenant or Lessor in its operation of the Building.

SUBORDINATION TO MORTGAGE AND GROUND LEASE

11. This Lease is subject and subordinate to any first and second lien mortgages or deeds of trust which may now or hereafter encumber the Building of which the leased premises form a part and to all renewals, modifications, consolidations, replacements and extensions thereof. This clause shall be self-operative and no further instrument of subordination need be required by any mortgagee. In confirmation of such subordination, however, Lessee shall at Lessor's request execute promptly any appropriate certificate or instrument that Lessor may reasonably request. Lessee hereby constitutes and appoints Lessor with the ability to execute any such certificate or instrument for and on behalf of Lessee. In the event of the enforcement by the trustee or the beneficiary under any such mortgage or deed of trust of the remedies provided for by law or by such mortgage or deed of trust, Lessee will, upon request of any person or party succeeding to the interest of Lessor as a result of such enforcement, automatically become the Lessee of such successor in interest without change in the terms or other provisions of such Lease; provided, however, that such successor in interest shall not be bound by (i) any payment of rent or additional rent for more than one month in advance, except prepayments in the nature of security for the performance by Lessee of its obligations under this Lease, or (ii) any amendment or modification of this Lease made without the written consent of such trustee or such beneficiary or such successor in interest. Upon request by such successor in interest, Lessee shall execute and deliver an instrument confirming the attornment herein provided for.

ESTOPPEL CERTIFICATE OR THREE PARTY AGREEMENT

12. At Lessor's request, Lessee will execute either an estoppel certificate addressed to Lessor's mortgagee or a three-party agreement among Lessor, Lessee and said mortgagee certifying to such facts (if true) and agreeing to such notice provisions and other matters as such mortgagee may reasonably require in connection with Lessor's financing.

V.

LESSOR AND LESSEE MUTUALLY COVENANT AND AGREE

CONDEMNATION AND LOSS OR DAMAGE

1. If the Leased Premises or access thereto shall be taken or condemned for any public purpose to such an extent as to render the Leased Premises untenantable, this Lease shall, at the option of either party, forthwith cease and terminate effective the date of taking. All proceeds from any taking or condemnation of the Leased Premises shall belong to and be paid to Lessor.

DAMAGES FROM CERTAIN CAUSES

2. Unless caused by the negligence or willful act or failure to act by Lessor, its agents or employees, Lessor shall not be liable or responsible to Lessee for any loss or damage to any property or person occasioned by theft, fire, act of God, public enemy, injunction, riot, strike, insurrection war, court order, requisition or order of governmental body or authority, or for any damage or inconvenience which may arise through repair or alteration of any part of the Building, or failure to make any such repairs.

LIEN FOR RENT

3. In consideration of the mutual benefits arising under this Agreement, Lessee hereby grants to Lessor a lien and security interest on all property of Lessee now or hereafter placed in or upon the Leased Premises, and such property shall be and remain subject to such lien and security interest of Lessor for payment of all rent and other sums agreed to relating to said lien and security interest shall constitute a security agreement under the Uniform Commercial Code so that Lessor shall have and may enforce a security interest on all property of Lessee now or hereafter placed in or on the Leased Premises, including, but not limited to, all fixtures, machinery, equipment, furnishings and other articles of personal property now or hereafter placed in or upon the Leased Premises by Lessee.

Lessee agrees to execute as debtor such financing statement or statements as Lessor may now or hereafter reasonably request in order that such security interest or interests may be protected pursuant to said Code. Lessor may, at its election, at any time, file a copy of this Lease as a financing statement. Lessor, as secured party, shall be entitled to all of the rights and remedies afforded a secured party under said Code in addition to and cumulative of the landlord's liens and rights provided by law or by the other terms and provisions of this lease.

LESSOR'S RIGHT TO RELET

4. In the event of default by Lessee in any of the terms and covenants of this Lease or in the event the Leased Premises are abandoned by Lessee, Lessor shall have the right, but not the obligation, to relet same for the remainder of the term provided for herein, and if the rent received through reletting does not at least equal the rent provided for herein, Lessee shall pay and satisfy the deficiency between the amount of the rent so provided for and that received through reletting, including, but not limited to, the cost of renovating, altering and decorating for a new occupant. Nothing herein shall be construed as in any way denying Lessor the right, in the event of abandonment of said premises or other breach of this Agreement by Lessee, to treat the same as an entire breach and, at Lessor's option, to terminate this Agreement and/or immediately seek recovery of the entire breach of this Agreement and any and all damages which Lessor suffers thereby.

HOLDING OVER

5. In the event of holding over by Lessee after expiration or termination of this Lease without the written consent of Lessor, Lessee shall pay as liquidated damages, double rent for the entire holdover period. No holding over by Lessee after the term of this Lease shall be construed to extend the Lease; in the event of any unauthorized holding over, Lessee shall indemnify Lessor against all claims for damages by any other Lessee to whom Lessor may have leased all or any part of the premises covered hereby effective upon the termination of this Lease. Any holding over with the consent of the Lessor in writing shall thereafter constitute this Lease a "Lease from month to month".

FIRE CLAUSE

6. In the event of a fire in the Leased Premises, Lessee shall immediately give notice thereof to Lessor. If the Leased Premises, through no fault or neglect of Lessee, its agents, employees, invitees or visitors shall be partially destroyed by fire or other casualty so as to render the premises untenantable, the rental provided for herein shall abate effective the date of casualty until such time as the Leased Premises are made tenantable as determined by Lessor. If the premises are not tenantable for a period of more than one hundred twenty (120) days, then Lessee shall have the option to cancel this Lease. In the event of the total destruction of the Leased Premises without fault or neglect of Lessee, its agents, employees, invitees or visitors, or if from any cause, the same shall be so damaged that Lessor shall decide not to rebuild, then all rent owed up to the time of such destruction shall be paid by Lessee and thenceforth this Lease shall cease and come to an end.

ATTORNEY'S FEES

7. If any legal action is necessary to enforce the terms of this Agreement, the prevailing party shall be entitled to reasonable attorney's fees and costs after all appeals have been exhausted and a judgment is final, which shall be in addition to other relief to which the prevailing party might be entitled.

ALTERATION

8. This Agreement may not be altered, changed or amended, except by an instrument in writing signed by both parties hereto.

ASSIGNMENT BY LESSOR

9. Lessor shall have the right to transfer and assign, in whole or in part, all its rights and obligations hereunder and in the Building and property referred to herein, and in such event and upon such transfer (any such transferee to have the benefit of, and be subject to, the provisions of Paragraphs 7 and 8 of Article III hereof) no further liability or obligation shall thereafter accrue against Lessor hereunder.

DEFAULT BY LESSEE

10. If default shall be made in the payment of any sum to be paid by Lessee under this Lease, and default shall continue for ten (10) days after written notice, or default shall be made in the performance of any of the other covenants or conditions which Lessee is required to observe and to perform, and such default shall continue for twenty (20) days after written notice, or if the interest of Lessee under this Lease shall be levied on under execution or other legal process, or if any petition shall be filed by or against Lessee to declare Lessee as bankrupt or to delay, reduce or modify Lessee's debts or obligations, or if any petition shall be filed or other action taken to reorganize or modify Lessee's capital structure if Lessee be a corporation or other entity, or if Lessee be declared insolvent according to law, or if any assignment of Lessee's property shall be made for the benefit of creditors, or if a receiver or trustee is appointed for Lessee or its property, or if Lessee shall abandon the Leased Premises during the term of this Lease or any renewals or extensions thereof, then Lessor may treat the occurrence of any one or more of the foregoing events as a breach of this Lease (provided that no such levy, execution, legal process or petition filed against Lessee shall constitute a breach of this Lease if Lessee shall vigorously contest the same by appropriate proceeding and shall remove or vacate the same within thirty (30) days from the date of its creation, service or filing) and thereupon, at Lessor's option, may have any one or more of the following described remedies in addition to all other rights and remedies provided at law or in equity:

(a) Lessor may terminate this Lease and forthwith repossess the Leased Premises and be entitled to recover forthwith as damages a sum of money equal to the total of (i) the cost of recovering the Leased Premises, (ii) the unpaid rent earned at the time of termination, plus interest at the rate of ten percent (10%) per annum from the due date, (iii) the balance of the rent for the remainder of the term less the fair market value of the Leased Premises for said period and (iv) any other sum of money and damages owed by Lessee to Lessor.

(b) Lessor may terminate Lessee's right of possession (but not the Lease) and may repossess the Leased Premises by forcible entry or detainer suit or otherwise, without demand or notice of any kind to Lessee and without terminating this Lease, in which event Lessor may, but shall be under no obligation to do so, relet the same for the account of Lessee for such rent and upon such terms as shall be satisfactory to Lessor. For the purpose of such reletting, Lessor is authorized to decorate or to make any repairs, changes, alterations or additions in or to Leased Premises that may be necessary or convenient, and (i) if Lessor shall fail or refuse to relet the Leased Premises, or (ii) if the same are relet and a sufficient sum shall not be realized from such reletting after paying the unpaid basic and additional rent due hereunder earned but unpaid at the time of reletting plus ten percent (10%) interest thereon, the cost of recovering possession, and all of the costs and expenses of such decorations, repairs, changes, alterations and additions and the expense of such reletting and of the collection of the rent accruing therefrom to satisfy the rent provided for in this Lease to be paid, then Lessee shall pay to Lessor as damages a sum equal to the amount of the rental reserved in this lease for such period or periods, or if the Leased Premises have been relet, the Lessee shall satisfy and pay any such deficiency upon demand therefor from time to time and Lessee agrees that Lessor may file suit to recover any sums falling due under the terms of this Article V, Paragraph 10(b) from time to time; and that no delivery or recovery of any portion due Lessor hereunder shall be any defense in any action to recover any amount not theretofore reduced to judgment in favor of Lessor, nor shall such reletting be construed as an election on the part of Lessor to terminate this Lease unless a written notice of such intention be given to Lessee by Lessor. Notwithstanding any such reletting without termination, Lessor may at any time thereafter elect to terminate this Lease for such previous breach.

NON-WAIVER

11. Failure of Lessor to declare any default immediately upon occurrence thereof, or delay in taking any action in connection therewith, shall not waive such default, but Lessor shall have the right to declare any such default at any time and take such action as might be lawful or authorized hereunder, either in law or in equity.

CASUALTY INSURANCE

12. Lessor shall maintain fire and extended coverage insurance on the portion of the Building constructed by Lessor, including additions and improvements by Lessee which are required to be made by Lessee by this Lease and which have become or are to become the property of Lessor upon vacation of the Leased Premises by Lessee. Said insurance shall be maintained with an insurance company authorized to do business in Tennessee in amounts desired by Lessor and at the expense of Lessor and payments for losses thereunder shall be made solely to Lessor. Lessee shall maintain, at its expense, fire and extended coverage insurance on all of its personal property, including removable trade fixtures, located in the Leased Premises and on all additions and improvements made by the Lessee and not required to be insured by Lessor above. If the annual premiums to be paid by Lessor shall exceed the standard rates because of Lessee's operations, contents of the Leased Premises, or improvements with respect to the Leased Premises beyond building standard which result in extrahazardous exposure, Lessee shall promptly pay the excess amount of the premium upon request by Lessor.

LESSOR'S AND LESSEE'S LIABILITY INSURANCE

13. Lessor and Lessee, at their own expense, shall each maintain a policy or policies of comprehensive general liability insurance with the premiums thereon fully paid on or before due date, issued by and binding upon some solvent insurance company, such insurance to afford minimum protection of not less than $300,000.00 in respect of personal injury or death in respect of any one occurrence and of not less than $100,000.00 for property damage in any one occurrence.

HOLD HARMLESS

14. Lessor shall not be liable to Lessee, or to Lessee's agents, servants, employees, customers or invitees for any damage to person or property caused by any act, omission or neglect of Lessee, its agents, servants or employees, and Lessee agrees to indemnify and hold Lessor harmless from all claims for any such damage. Lessee shall not be liable to Lessor, or to Lessors' agents, servants, employees, customers or invitees for any damage to person or property caused by any act, omission or neglect of Lessor, its agents, servants or employees, and Lessor agrees to indemnify and hold Lessee harmless from all claims for any such damage.

WAIVER OF SUBROGATION

15. Anything in this Lease to the contrary notwithstanding, Lessor and Lessee each hereby waive any and all rights of recovery, claim, action or cause of action against the other, its agents, officers or employees for any loss or damage that may occur to the Leased Premises; or any improvements thereto, or said Building of which the Leased Premises are a part, or any improvements thereto, or any personal property of such party therein, by reason of fire, the elements, or any other cause which could be insured against under the terms of standard fire and extended coverage insurance policies referred to in Article V, Paragraph 12 hereof, regardless of cause or origin, including negligence of the other party hereto, its agents, officers or employees, and covenants that no insurer shall hold any right of subrogation against such other party.

This Lease shall be binding upon and inure to the benefit of the successors and assigns of Lessor, and shall be binding upon and inure to the benefit of Lessee, its successors, and, to the extent assignment may be approved by Lessor hereunder, Lessee's assigns. The pronouns of any gender shall include the other gender and either the singular or the plural shall include the other.

All rights and remedies of Lessor under this Lease shall be cumulative and none shall exclude any other rights or remedies allowed by law; and this Lease is declared to be a Tennessee contract, and all of the terms thereof shall be construed according to the laws of the State of Tennessee.

SPECIAL

17. Lessor agrees to give a Right Of First Refusal to Lessee for suite 210 (Exhibit B1- 1,493.4 r.s.f.) in the Anderson Building. Lessor shall make known to Lessee, via written or e-mail notification, the date of availability/marketability of suite 210 in the Anderson Building. Upon such notification from Lessor, Lessee shall have thirty (30) days to respond, via written notification or e-mail, to Lessors notification. Should Lessee fail to respond to Lessor's notification within the prescribed time frame, Lessee shall forfeit his right under this lease agreement of his Right Of First Refusal for suite 210 in the Anderson Building. Should Lessor receive from Lessee notification, within the time frame prescribed above, of Lessee's desire to acquire suite 210 (Exhibit B1- 1,493.4 r.s.f.), Lessor agrees and covenants with Lessee to lease suite 210 (Exhibit B1- 1,493.4 r.s.f.), at the base rental rate currently laid out in the payment schedule for suite 208, (Exhibit A). Upon the signing of a mutually agreed upon addendum describing the date of acquisition of suite 210 by Lessee, Lessor shall provide $2.00 per foot, per year, in build-out allowance to renovate suite 210. (Example: Should Lessee obtain suite 210 as proscribed above and there are four (4) years remaining in this lease agreement, than Lessor shall provide $11,947.20 in allowance. $2.00 x 1493.4 = $2,986.80 x 4 = $11,947.20) Should the date of physical acquisition for suite 210 be other than the first (1st) day of the month, a pro rata base rental rate shall be applied and be payable to Lessor before Lessee shall take possession of same. In the event Lessee shall take possession of suite 210 (Exhibit B1- 1,493.4 r.s.f.) the Net Rentable Area defined by this agreement will increase from 5,383.08 r.s.f. to 6,876.48 r.s.f. and be subject to all the terms and conditions set forth herein.

IN TESTIMONY WHEREOF the parties hereto have executed this Lease as of the date aforesaid.

LESSOR: NOL, LLC

By: _____
Scott D. Mathiesen

Title: Property/Facility Manager

LESSEE:

By: _____
Dr. Terry Totty

Title: President

LESSEE:

By: _____
Dr. Lance Benedict

Title: Secretary

NOTICES:

LESSOR:
NOL, LLC
28 White Bridge Road
Nashville, TN 37205

LESSEE:
TN Spine & Nerve Institute, Inc.
28 White Bridge Road, Suite 208
Nashville, TN 37205

LESSEE:
TN Spine & Nerve Institute, Inc.
28 White Bridge Road, Suite 208
Nashville, TN 37205

STATE OF TENNESSEE

COUNTY OF DAVIDSON

BEFORE ME, the undersigned, a Notary Public in and for said County and State, on this day personally appeared William R. DeLoache, Jr., who acknowledged to me that he executed the same for the purposes and consideration therein stated, and as the act of said Partnership.

GIVEN UNDER MY HAND AND SEAL OF OFFICE, this the 9th day of September, 09.

Lana M. Totty
Notary Public
My commission expires: March 7, 2011

LANA M. TOTTY
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY

My Commission Expires March 7, 2011

STATE OF TENNESSEE

COUNTY OF DAVIDSON

BEFORE ME, the undersigned, a Notary Public in and for said County and State, on this day personally appeared Lana M. Totty, known to me to be the person and officer whose name is subscribed to the foregoing instrument, and acknowledged to me that he/she executed same as the act and deed of such _____, for the purposes and consideration therein expressed and in the capacity therein stated.

GIVEN UNDER MY HAND AND SEAL OF OFFICE, this the 9th day of September, 09.

Lana M. Totty
Notary Public
My commission expires: March, 7, 2011

LANA M. TOTTY
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY

My Commission Expires March 7, 2011

EXHIBIT A

LEASE BETWEEN NOL, LLC AND
TENNESSEE SPINE AND NERVE INSTITUTE, INC.
September 1, 2009

1. Base rental for the leased space shall be as follows:

		Suite 208
9/1/09 – 8/31/10	$21.25 per square foot per year	$114,390.45 annually
9/1/10 – 8/31/11	$21.75 per square foot per year	$117,081.99 annually
9/1/11 – 8/31/12	$22.25 per square foot per year	$119,773.53 annually
9/1/12 – 8/31/13	$22.75 per square foot per year	$122,465.07 annually
9/1/13 –8/31/14	$23.50 per square foot per year	$126,502.38 annually
9/1/14 – 8/31/15	$24.25 per square foot per year	$130,539.69 annually
9/1/15 – 8/31/16	$25.00 per square foot per year	$134,577.00 annually

2. Finish Work

Upon the signing of this agreement, Lessor agrees to install, at his initial cost, new carpet (Masland, Verve, 7811R-18112 Oscar, 32oz.) in the areas of suite 208 currently carpeted. Carpet installation will be performed only by Lessor's agents and shall not exceed $19,249.36. Lessor agrees to have his agents repaint, at his initial cost, suite 208 in a fashion similar to its current style, which cost shall not exceed $5,350.00. Lessor further agrees to initially pay for a work area which was recently installed by Harvest Construction at a cost of $5,156.00. The total initial cost Lessor agrees to contribute to the upgrade of suite 208 shall be no greater than $29,755.36. Lessee hereby covenants and agrees to reimburse Lessor all of the $29,755.36 Lessor has contributed toward the upgrade of suite 208. Lessee agrees to make equal monthly payments to Lessor of $354.23. Payments shall be made to Lessor on the first day of every month and for not less than eighty four (84) consecutive months. The carpet installation and painting shall be completed within forty five (45) days of the signing of this lease agreement. The payment to Harvest Construction of $5,156.00 shall be made in a timely manner (not greater than ten (10) days) after the signing of this lease agreement.

Guarantors waive notices of acceptance of this Guaranty, and agree that this Guaranty shall be a continuing one.

Notice of any and all defaults on the part of Tenant, and any successor of Tenant or assignee of Tenant, is waived, and consent is given to all extensions of time, waivers or indulgences of any kind, that Lessor, its successors or assigns, may grant to Tenant, and any successor of Tenant or assignee of Tenant, with reference to the performance by Tenant or any successor of Tenant or assignee of Tenant, of any of the terms, obligations, covenants or agreements in or under the Lease.

Guarantors, without limiting any of the foregoing provisions of this Guaranty, also waive notice of any and all changes, modifications or amendments in, of or to the Lease that may be agreed upon between Lessor or its successors or assigns and Tenant, or Tenant's successors or assigns.

IN WITNESS WHEREOF, Guarantors and Lessor have caused this Guaranty to be executed as of the day and year first above written.

Witness

GUARANTORS:

Signature

Print Name: TERRY D. TOTH
SSN: 479-54-7972
Date of Birth: 5/10/51

Witness

Signature

Print Name: LANCE C. BENEDICT
SSN: 052-56-6401
Date of Birth: 6/3/60

Amendment to Lease

March 1, 2010

THIS AMENDMENT TO LEASE (the "Amendment") is made and entered into as of the 1st day of March, 2010, by and between NOL, LLC, a Tennessee Limited Liability Corporation ("Lessor") and Tennessee Spine and Nerve Institute, Inc., a Tennessee Corporation ("Lessee").

WHEREAS, Lessor and Lessee entered into that certain lease dated September 1, 2009, for certain real property located at 28 White Bridge Road, Nashville, Tennessee 37205, (the "Lease"); and

WHEREAS, both Lessor and Lessee desire to amend the Lease.

NOW THEREFORE, for and in consideration of the mutual covenants contained herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree to amend the Lease as follows:

1. Section I LEASED PREMISES, is hereby amended, effective as of July 1, 2010, by adding 1,493.40 gross square feet on the second floor as more particularly described in Exhibit B, so that the total Leased Premises shall thereafter be 6,876.48 square feet on the second floor.
2. Section II BASE RENTAL (4) (a), is hereby amended so that the Net Rentable Area for purposes of the base rental adjustment shall be 6,876.48 square feet (an addition of 1,493.40 square feet).
3. Exhibit A (1), is hereby amended as follows:

9/1/09 – 6/30/10	$21.25 per square foot per year	$9,532.53 monthly
7/1/10 – 8/31/10	$22.22 per square foot per year	$12,733.89 mthly/$152,806.70 annually
9/1/10 – 8/31/11	$22.79 per square foot per year	$13,059.58 mthly/$156,715.00 annually
9/1/11 – 8/31/12	$23.29 per square foot per year	$13,346.10 mthly/$160,153.20 annually
9/1/12 – 8/31/13	$23.79 per square foot per year	$13,632.62 mthly/$163,591.50 annually
9/1/13 – 8/31/14	$24.54 per square foot per year	$14,062.40 mthly/$168,748.80 annually
9/1/14 – 8/31/15	$25.29 per square foot per year	$14,492.18 mthly/$173,906.20 annually
9/1/15 – 8/31/16	$26.04 per square foot per year	$14,921.96 mthly/$179,063.50 annually

The amended base square foot rates above shall not be construed as total rental fees owed to Lessor under the lease agreement dated September 1, 2009. The square foot rates noted above from 7/1/10 to 8/31/16 are reflective of an amended Section 17, whereby Lessor agrees to provide a total sum of $20,000.00 for the purpose of build-out of suite 210. The total build-out cost(s) to Lessor shall not exceed $20,000.00. Any build-out costs in/to suite 210 which exceed $20,000.00 shall be borne exclusively by Lessee. Should build-out expenses exceed the limit of $20,000.00, Lessor shall submit to Lessee on the next monthly rental invoice for Tennessee Spine and Nerve Institute, Inc., a request for payment of all costs held in excess, which shall be paid in full upon receipt.

Furthermore, Lessor reserves exclusive right to select, via bid process, competent contractor(s) to perform all renovations set forth in a set of stamped architectural plans, provided by Lessee. Lessee agrees to provide said architectural drawings at Lessee's expense. This set of stamped architectural plans, drawn for the augmentation of suite 210, shall comply with all pertinent federal, state and local codes and laws governing the remodeling of existing commercial office space. Upon completion of all renovations Lessee agrees to provide, at his expense, a PDF file of the as-built state of suite 210 to Lessor, in a format congruent with existing PDF suite drawings in the Anderson Building.

4. All other terms of the original Lease Agreement shall remain as previously stated in the original Lease

IN TESTIMONY WHEREOF the parties hereto have executed this Amendment as of the date aforesaid.

LESSOR: NOL, LLC

By: _____
Scott D. Mathiesen
Title: Property/Facility Manager

LESSEE:

By: _____
Dr. Terry Totty
Title: President

LESSEE:

By: _____
Dr. Lance Benedict
Title: Secretary

NOTICES

LESSOR:
NOL, LLC
28 White Bridge Road
Nashville, TN 37205

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TN Spine & Nerve Institute, Inc.
28 White Bridge Road
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LESSEE:
TN Spine & Nerve Institute, Inc.
28 White Bridge Road
Nashville, TN 37205

ASSIGNMENT AGREEMENT

THIS ASSIGNMENT AGREEMENT ("Assignment") is entered into the 01st day of September, 2010, by and between Tennessee Spine and Nerve Institute, Inc. ("Grantor"), and MUA of Middle Tennessee, LLC ("Grantee").

RECITALS:

WHEREAS, Grantor leases certain property at 28 White Bridge Road, # 210, Nashville, Davidson County, TN 37205; and

WHEREAS, Grantee is in the process of applying for a certificate of need in order to establish a new specialty ambulatory surgical treatment center ("ASTC") providing manipulation under anesthesia services, only, at the same location of 28 White Bridge Road, # 210, Nashville, Davidson County, TN 37205; and

WHEREAS, Grantee requires site control of the location mentioned above in order to establish a new specialty ASTC at that site;

NOW, THEREFORE, for good and valuable consideration, the receipt and legal sufficiency of which are hereby acknowledged, the parties, intending to be legally bound hereby, agree as follows:

1. ASSIGNMENT OF OPTION TO PURCHASE: In consideration of the sum of One Dollar ($1.00), cash in hand paid, and other good and valuable consideration of Grantee's developing a new specialty ASTC on the above-mentioned site, the receipt and legal adequacy of which consideration is hereby acknowledged by Grantor, Grantor hereby grants this Assignment to Grantee for six (6) years for a total of $251,238.54, to be paid per the increased amounts of the Amendment to Lease executed by Grantor and NOL, LLC, ("Landlord"), which Amendment to Lease has an effective date of March 01, 2010.

2. LENGTH OF ASSIGNMENT: This Assignment shall be continuing and irrevocable for six (6) years, beginning September 01, 2010 through August 31, 2016.

This Assignment shall be binding upon and shall inure to the benefit of the parties hereto and their respective heirs, executors, administrators and assigns.

IN WITNESS WHEREOF, the parties have executed this Assignment as of the date first above written.

GRANTOR:

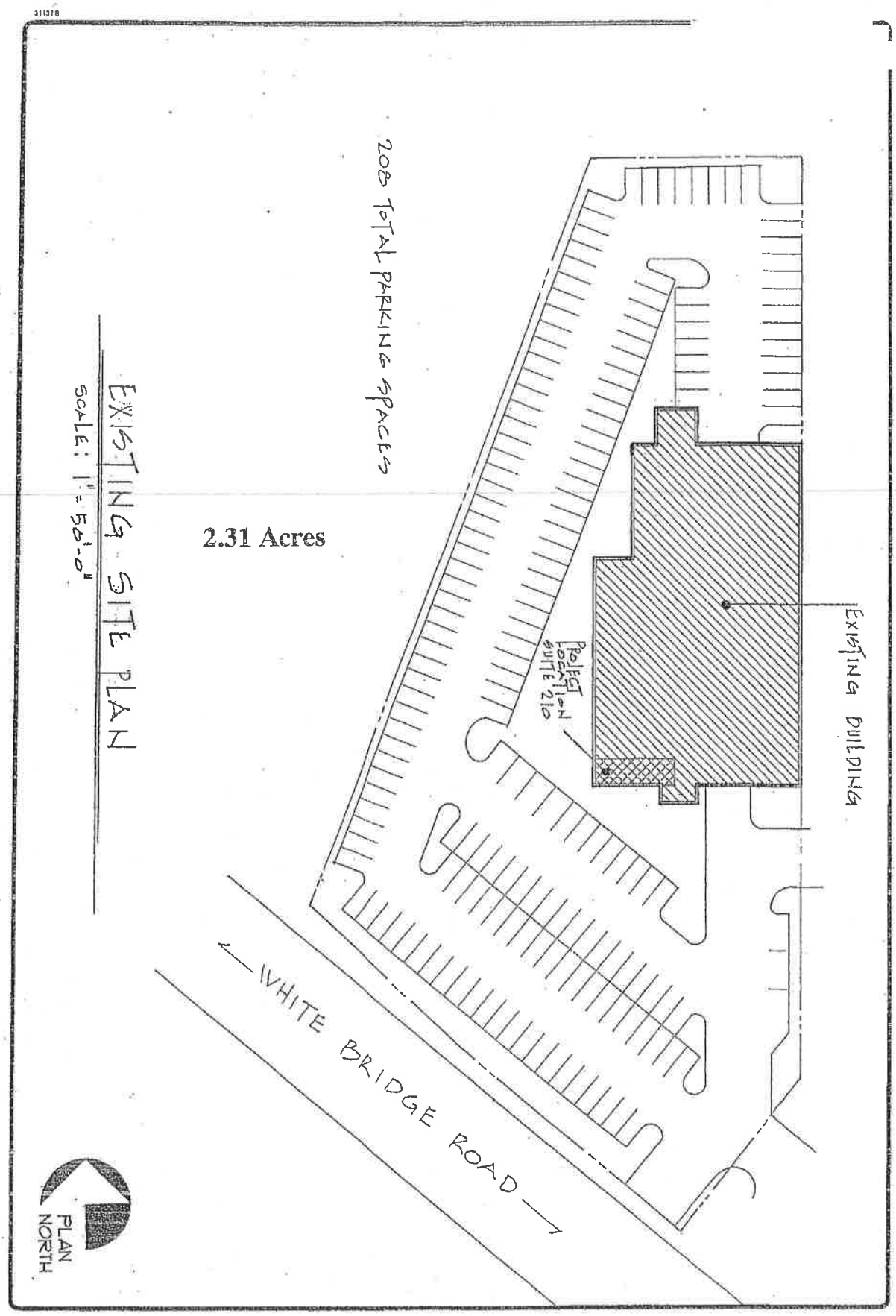
TENNESSEE SPINE AND NERVE INSTITUTE, INC.

By: E. Graham Baker, Jr. LIMITED AGENT
E. Graham Baker, Jr., Esq., Limited Agent

GRANTEE:

MUA OF MIDDLE TENNESSEE, LLC

By: E. Graham Baker, Jr. LIMITED AGENT
E. Graham Baker, Jr., Esq., Limited Agent



DRAWN	
CHECKED	
DATE	9/16/10
SCALE	
JOB NO.	
SHEET	CM-1
OF SHEETS	

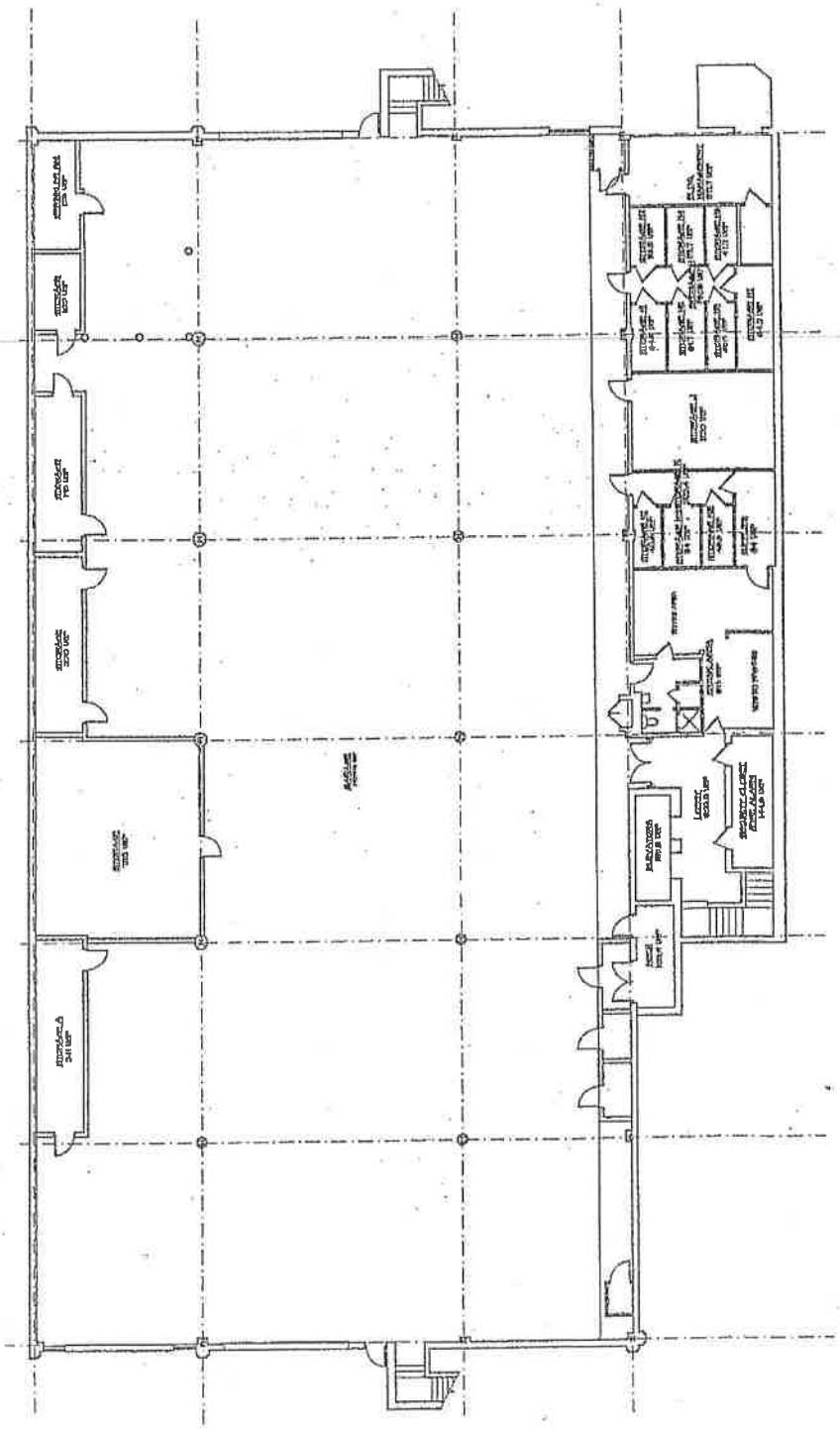
MIA OF MIDDLE TENNESSEE, LLC
SUITE 210 28 WHITE BRIDGE ROAD
NASHVILLE , TENNESSEE

REVISIONS	BY

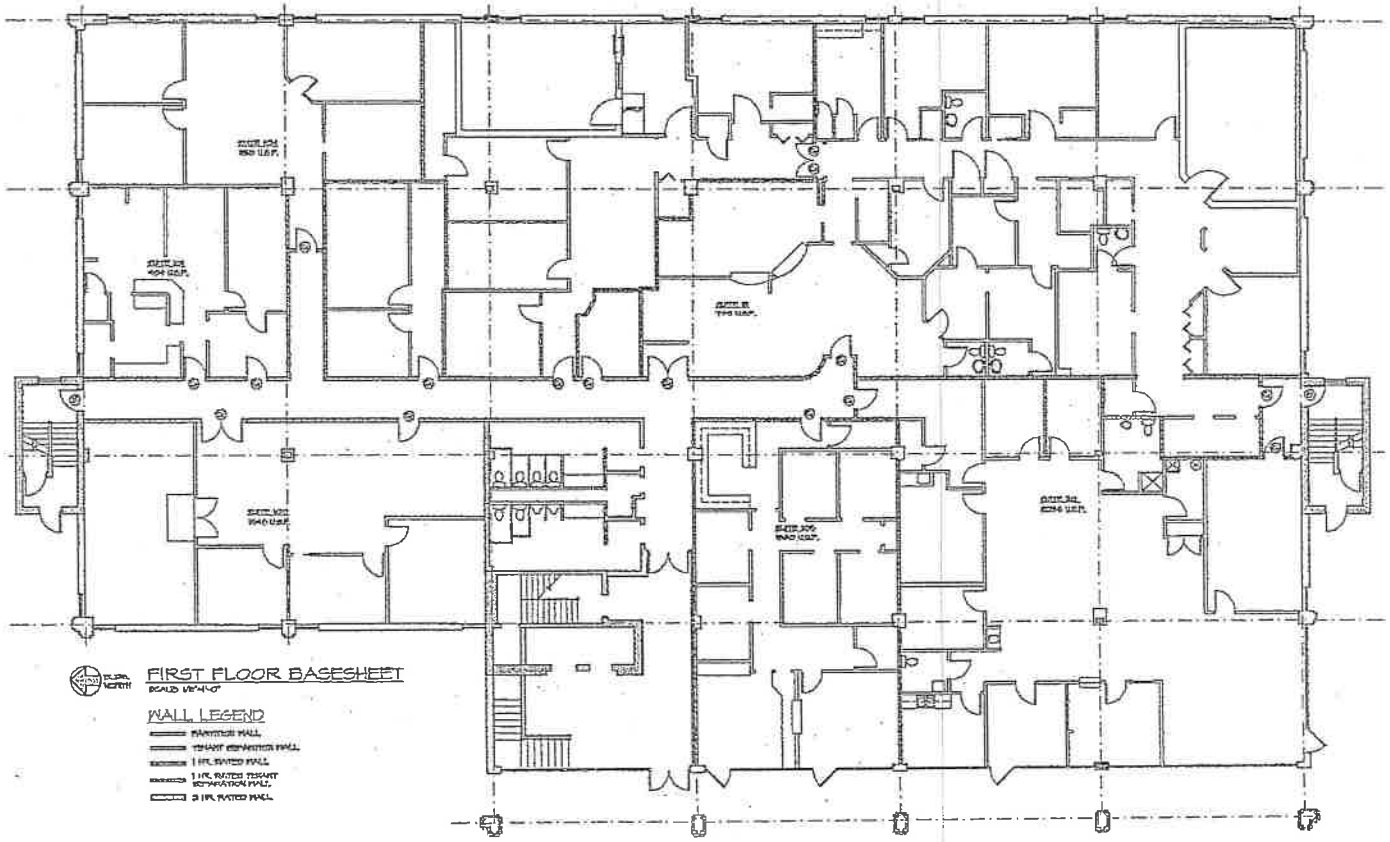
ANDERSON BUILDING

ANDERSON BUILDING

January 23, 2008



ANDERSON BUILDING



FIRST FLOOR BASESHEET

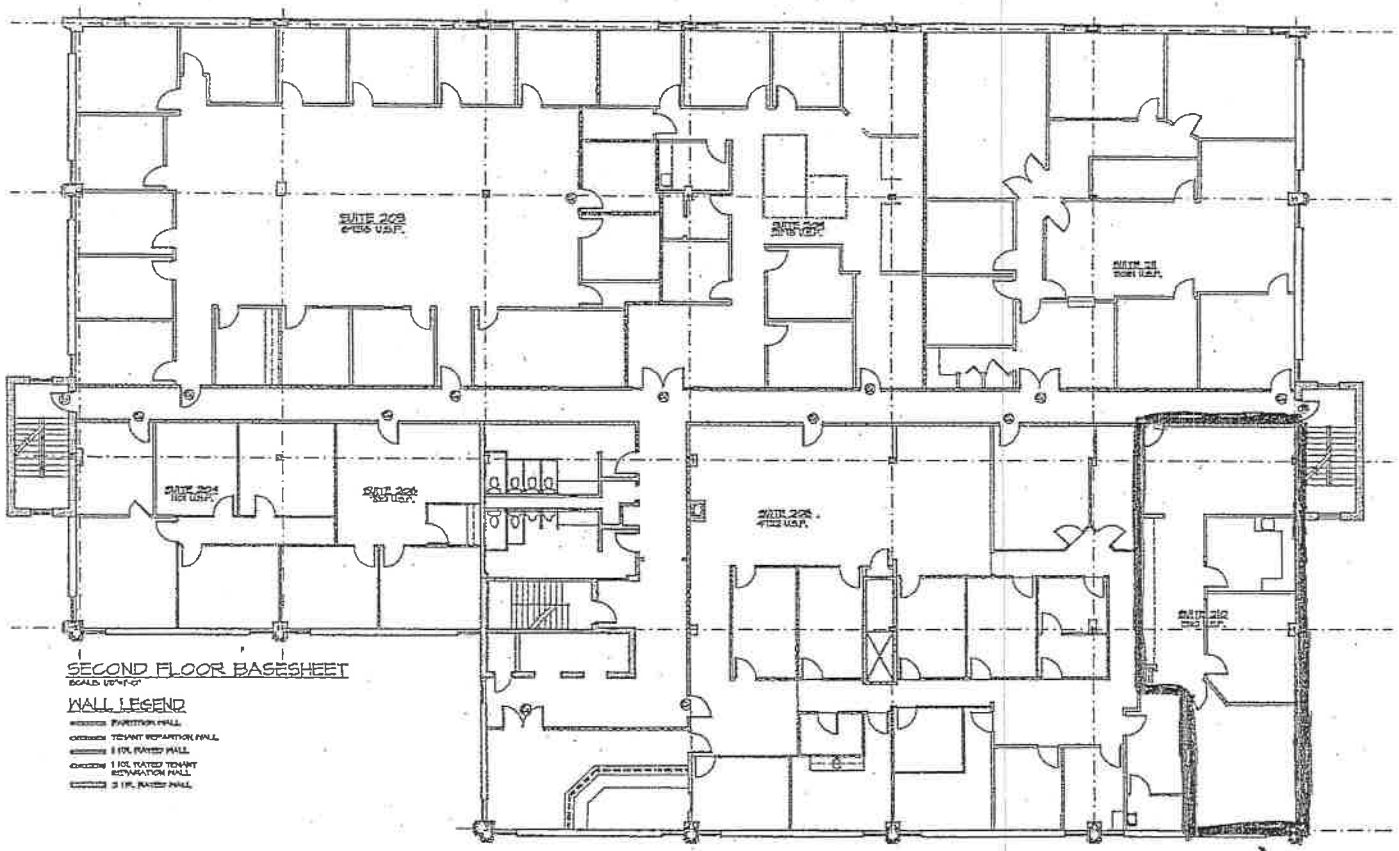
WALL LEGEND

DOOR TYPE:

ANDERSON BUILDING

January 28, 2008

ANDERSON BUILDING



SECOND FLOOR BASESHEET

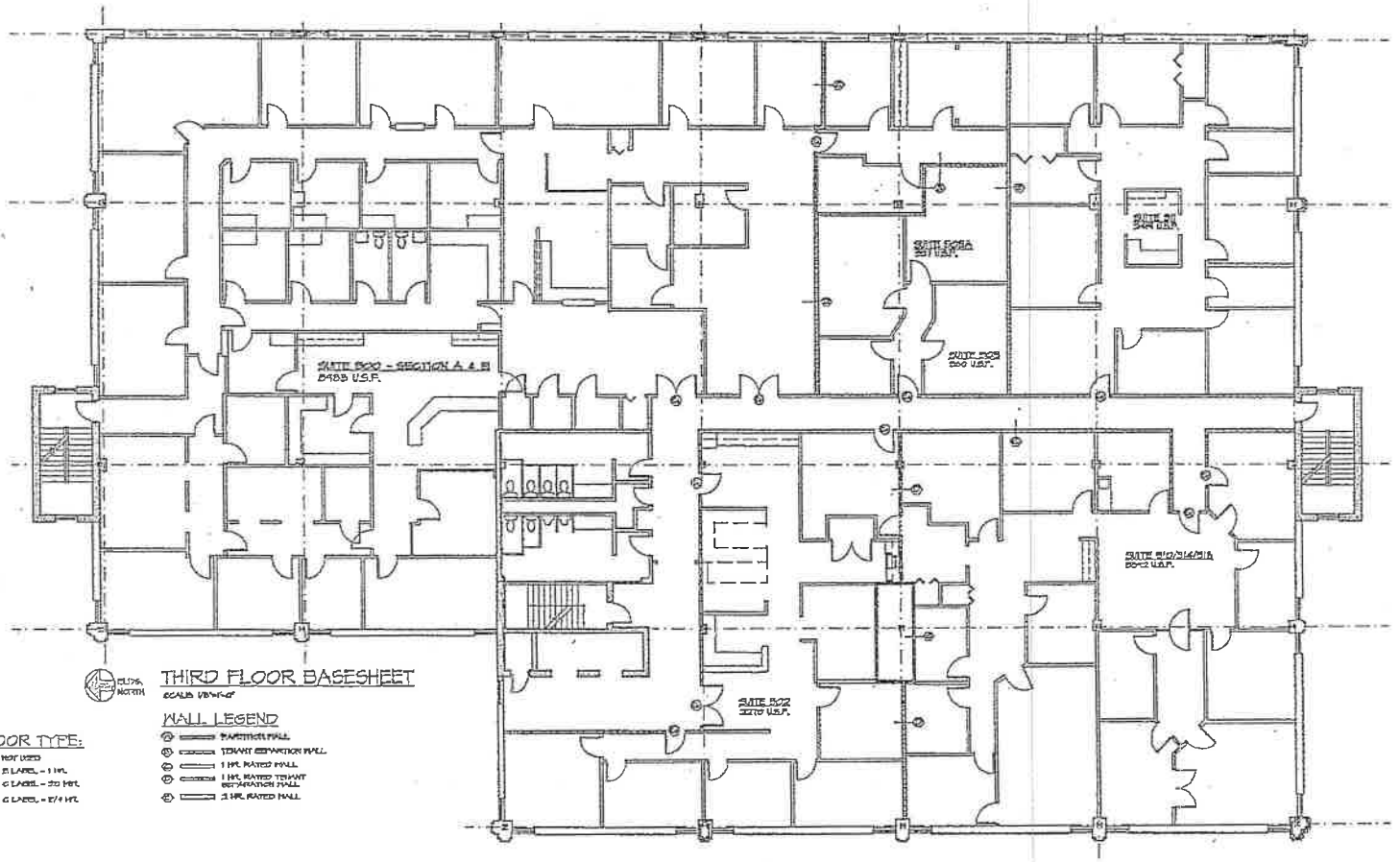
WALL LEGEND

DOOR TYPES

ANDERSON BUILDING
38 WHITE BRIDGE ROAD, Nashville, Tennessee

January 23, 2003

A-2



THIRD FLOOR BASESHEET

SCALE: 1/8"=1'-0"

WALL LEGEND

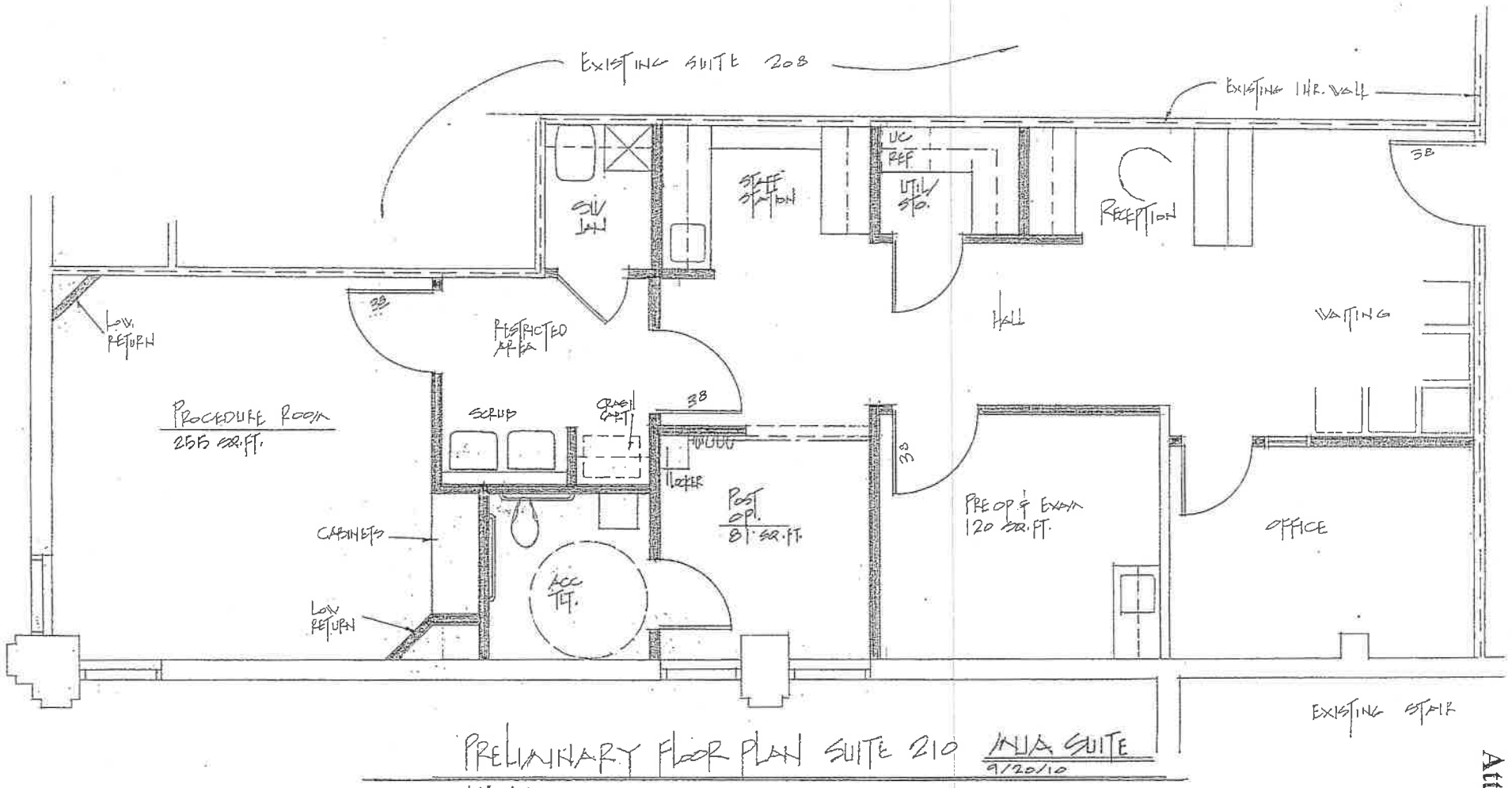
- PARTITION WALL
- TENANT SEPARATION WALL
- 1 HR. RATED WALL
- 1 HR. RATED TENANT SEPARATION WALL
- 2 HR. RATED WALL

DOOR TYPE:

- NOT USED
- B LABEL - 1 HR.
- C LABEL - 3/4 HR.
- D LABEL - 1 1/2 HR.

ANDERSON BUILDI

January 31, 2008



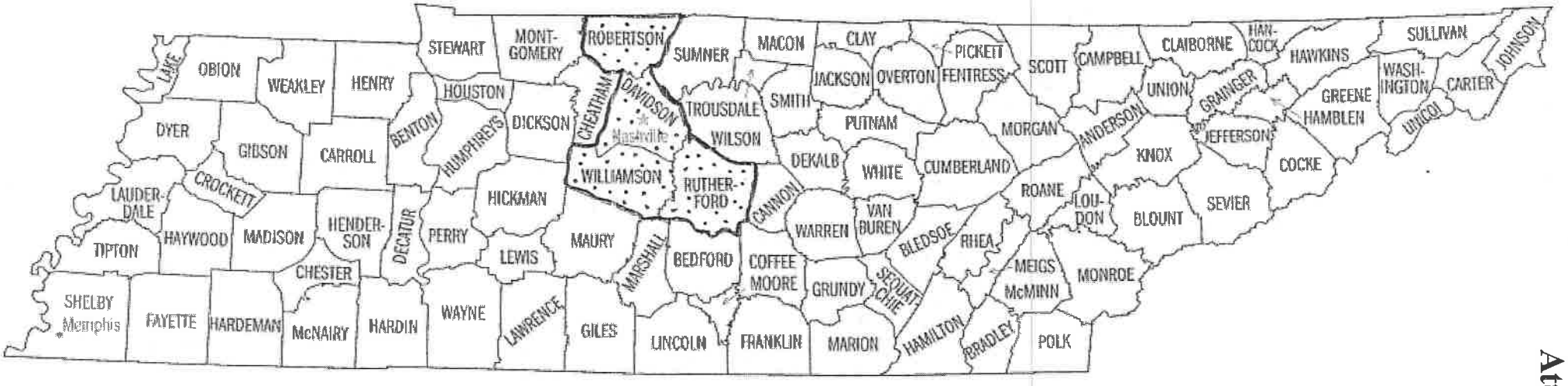
PRELIMINARY FLOOR PLAN SUITE 210 INIA SUITE

9/20/10

1/4"=1'-0"

Attachment B.IV

Tennessee County Map



Attachment C.Need.3

State & County QuickFacts

Davidson County, Tennessee

People QuickFacts	Davidson County	Tennessee
Population, 2012 estimate	648,295	6,456,243
Population, 2010 (April 1) estimates base	626,684	6,346,113
Population, percent change, April 1, 2010 to July 1, 2012	3.4%	1.7%
Population, 2010	626,681	6,346,105
Persons under 5 years, percent, 2011	7.1%	6.3%
Persons under 18 years, percent, 2011	21.8%	23.3%
Persons 65 years and over, percent, 2011	10.5%	13.7%
Female persons, percent, 2011	51.6%	51.3%
White persons, percent, 2011 (a)	66.2%	79.5%
Black persons, percent, 2011 (a)	27.9%	16.9%
American Indian and Alaska Native persons, percent, 2011 (a)	0.5%	0.4%
Asian persons, percent, 2011 (a)	3.2%	1.5%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	0.1%	0.1%
Persons reporting two or more races, percent, 2011	2.1%	1.6%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	9.9%	4.7%
White persons not Hispanic, percent, 2011	57.5%	75.4%
Living in same house 1 year & over, percent, 2007-2011	79.3%	84.1%
Foreign born persons, percent, 2007-2011	11.7%	4.5%
Language other than English spoken at home, percent age 5+, 2007-2011	15.4%	6.4%
High school graduate or higher, percent of persons age 25+, 2007-2011	85.3%	83.2%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	34.4%	23.0%
Veterans, 2007-2011	40,017	501,665
Mean travel time to work (minutes), workers age 16+, 2007 -2011	23.2	24.0
Housing units, 2011	285,020	2,829,025
Homeownership rate, 2007-2011	56.8%	69.0%
Housing units in multi-unit structures, percent, 2007-2011	37.1%	18.1%
Median value of owner-occupied housing units, 2007-2011	$166,300	$137,200
Households, 2007-2011	254,111	2,457,997
Persons per household, 2007-2011	2.35	2.50
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$28,526	$24,197
Median household income, 2007-2011	$46,737	$43,989
Persons below poverty level, percent, 2007-2011	17.7%	16.9%

Business QuickFacts	Davidson County	Tennessee
Private nonfarm establishments, 2010	18,124	131,582[1]
Private nonfarm employment, 2010	370,484	2,264,032[1]
Private nonfarm employment, percent change, 2000-2010	-7.0	-5.3[1]
Nonemployer establishments, 2010	54,350	465,545
Total number of firms, 2007	64,653	545,348
Black-owned firms, percent, 2007	11.1%	8.4%
American Indian- and Alaska Native-owned firms, percent, 2007	0.6%	0.5%
Asian-owned firms, percent, 2007	3.4%	2.0%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	0.1%	0.1%
Hispanic-owned firms, percent, 2007	2.9%	1.6%
Women-owned firms, percent, 2007	26.8%	25.9%
Manufacturers shipments, 2007 ($1000)	7,347,204	140,447,760

Merchant wholesaler sales, 2007 ($1000)	11,942,568	80,116,528
Retail sales, 2007 ($1000)	10,581,843	77,547,291
Retail sales per capita, 2007	$17,029	$12,563
Accommodation and food services sales, 2007 ($1000)	2,202,982	10,626,759
Building permits, 2011	1,966	14,977

Geography QuickFacts	Davidson County	Tennessee
Land area in square miles, 2010	504.03	41,234.90
Persons per square mile, 2010	1,243.3	153.9
FIPS Code	037	47
Metropolitan or Micropolitan Statistical Area	Nashville-Davidson--Murfreesboro--Franklin, TN Metro Area	

1: Includes data not distributed by county.

(a) Includes persons reporting only one race.
(b) Hispanics may be of any race, so also are included in applicable race categories.

D: Suppressed to avoid disclosure of confidential information
F: Fewer than 100 firms
FN: Footnote on this item for this area in place of data
NA: Not available
S: Suppressed; does not meet publication standards
X: Not applicable
Z: Value greater than zero but less than half unit of measure shown

Source U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits, Consolidated Federal Funds Report
Last Revised: Monday, 11-Mar-2013 14:19:24 EDT

State & County QuickFacts

Robertson County, Tennessee

People QuickFacts	Robertson County	Tennessee
Population, 2012 estimate	66,931	6,456,243
Population, 2010 (April 1) estimates base	66,283	6,346,113
Population, percent change, April 1, 2010 to July 1, 2012	1.0%	1.7%
Population, 2010	66,283	6,346,105
Persons under 5 years, percent, 2011	6.9%	6.3%
Persons under 18 years, percent, 2011	25.7%	23.3%
Persons 65 years and over, percent, 2011	12.1%	13.7%
Female persons, percent, 2011	50.8%	51.3%
White persons, percent, 2011 (a)	89.9%	79.5%
Black persons, percent, 2011 (a)	7.7%	16.9%
American Indian and Alaska Native persons, percent, 2011 (a)	0.5%	0.4%
Asian persons, percent, 2011 (a)	0.6%	1.5%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	0.1%	0.1%
Persons reporting two or more races, percent, 2011	1.3%	1.6%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	6.1%	4.7%
White persons not Hispanic, percent, 2011	84.4%	75.4%
Living in same house 1 year & over, percent, 2007-2011	87.3%	84.1%
Foreign born persons, percent, 2007-2011	4.1%	4.5%
Language other than English spoken at home, percent age 5+, 2007-2011	5.8%	6.4%
High school graduate or higher, percent of persons age 25+, 2007-2011	82.7%	83.2%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	15.2%	23.0%
Veterans, 2007-2011	4,816	501,665
Mean travel time to work (minutes), workers age 16+, 2007 -2011	29.1	24.0
Housing units, 2011	26,264	2,829,025
Homeownership rate, 2007-2011	77.0%	69.0%
Housing units in multi-unit structures, percent, 2007-2011	8.6%	18.1%
Median value of owner-occupied housing units, 2007-2011	$153,900	$137,200
Households, 2007-2011	24,028	2,457,997
Persons per household, 2007-2011	2.70	2.50
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$22,937	$24,197
Median household income, 2007-2011	$50,759	$43,989
Persons below poverty level, percent, 2007-2011	13.2%	16.9%

Business QuickFacts	Robertson County	Tennessee
Private nonfarm establishments, 2010	1,060	131,582[1]
Private nonfarm employment, 2010	15,638	2,264,032[1]
Private nonfarm employment, percent change, 2000-2010	12.5	-5.3[1]
Nonemployer establishments, 2010	4,931	465,545
Total number of firms, 2007	5,745	545,348
Black-owned firms, percent, 2007	1.9%	8.4%
American Indian- and Alaska Native-owned firms, percent, 2007	S	0.5%
Asian-owned firms, percent, 2007	S	2.0%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	F	0.1%
Hispanic-owned firms, percent, 2007	2.3%	1.6%
Women-owned firms, percent, 2007	26.3%	25.9%
Manufacturers shipments, 2007 ($1000)	1,667,466	140,447,760

Merchant wholesaler sales, 2007 ($1000)	779,419	80,116,528
Retail sales, 2007 ($1000)	627,764	77,547,291
Retail sales per capita, 2007	$9,862	$12,563
Accommodation and food services sales, 2007 ($1000)	60,729	10,626,759
Building permits, 2011	142	14,977

Geography QuickFacts	Robertson County	Tennessee
Land area in square miles, 2010	476.29	41,234.90
Persons per square mile, 2010	139.2	153.9
FIPS Code	147	47
Metropolitan or Micropolitan Statistical Area	Nashville-Davidson--Murfreesboro--Franklin, TN Metro Area	

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Last Revised: Monday, 11-Mar-2013 14:19:38 EDT

State & County QuickFacts

Rutherford County, Tennessee

People QuickFacts	Rutherford County	Tennessee
Population, 2012 estimate	274,454	6,456,243
Population, 2010 (April 1) estimates base	262,604	6,346,113
Population, percent change, April 1, 2010 to July 1, 2012	4.5%	1.7%
Population, 2010	262,604	6,346,105
Persons under 5 years, percent, 2011	7.1%	6.3%
Persons under 18 years, percent, 2011	25.8%	23.3%
Persons 65 years and over, percent, 2011	8.5%	13.7%
Female persons, percent, 2011	50.6%	51.3%
White persons, percent, 2011 (a)	81.2%	79.5%
Black persons, percent, 2011 (a)	12.9%	16.9%
American Indian and Alaska Native persons, percent, 2011 (a)	0.5%	0.4%
Asian persons, percent, 2011 (a)	3.1%	1.5%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	0.1%	0.1%
Persons reporting two or more races, percent, 2011	2.1%	1.6%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	6.9%	4.7%
White persons not Hispanic, percent, 2011	75.3%	75.4%
Living in same house 1 year & over, percent, 2007-2011	80.8%	84.1%
Foreign born persons, percent, 2007-2011	6.6%	4.5%
Language other than English spoken at home, percent age 5+, 2007-2011	9.3%	6.4%
High school graduate or higher, percent of persons age 25+, 2007-2011	88.8%	83.2%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	27.0%	23.0%
Veterans, 2007-2011	18,492	501,665
Mean travel time to work (minutes), workers age 16+, 2007 -2011	26.4	24.0
Housing units, 2011	103,913	2,829,025
Homeownership rate, 2007-2011	69.0%	69.0%
Housing units in multi-unit structures, percent, 2007-2011	19.6%	18.1%
Median value of owner-occupied housing units, 2007-2011	$159,600	$137,200
Households, 2007-2011	94,173	2,457,997
Persons per household, 2007-2011	2.67	2.50
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$24,879	$24,197
Median household income, 2007-2011	$54,433	$43,989
Persons below poverty level, percent, 2007-2011	12.7%	16.9%

Business QuickFacts	Rutherford County	Tennessee
Private nonfarm establishments, 2010	4,497	131,582[1]
Private nonfarm employment, 2010	82,514	2,264,032[1]
Private nonfarm employment, percent change, 2000-2010	15.1	-5.3[1]
Nonemployer establishments, 2010	17,493	465,545
Total number of firms, 2007	20,939	545,348
Black-owned firms, percent, 2007	6.1%	8.4%
American Indian- and Alaska Native-owned firms, percent, 2007	S	0.5%
Asian-owned firms, percent, 2007	2.6%	2.0%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	F	0.1%
Hispanic-owned firms, percent, 2007	2.7%	1.6%
Women-owned firms, percent, 2007	25.3%	25.9%
Manufacturers shipments, 2007 ($1000)	11,304,846	140,447,760

Merchant wholesaler sales, 2007 ($1000)	6,226,284	80,116,528
Retail sales, 2007 ($1000)	2,804,294	77,547,291
Retail sales per capita, 2007	$11,588	$12,563
Accommodation and food services sales, 2007 ($1000)	386,963	10,626,759
Building permits, 2011	866	14,977

Geography QuickFacts	Rutherford County	Tennessee
Land area in square miles, 2010	619.36	41,234.90
Persons per square mile, 2010	424.0	153.9
FIPS Code	149	47
Metropolitan or Micropolitan Statistical Area	Nashville-Davidson--Murfreesboro--Franklin, TN Metro Area	

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White persons, percent, 2011 (a)	81.2%	79.5%
Black persons, percent, 2011 (a)	12.9%	16.9%
American Indian and Alaska Native persons, percent, 2011 (a)	0.5%	0.4%
Asian persons, percent, 2011 (a)	3.1%	1.5%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	0.1%	0.1%
Persons reporting two or more races, percent, 2011	2.1%	1.6%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	6.9%	4.7%
White persons not Hispanic, percent, 2011	75.3%	75.4%
Living in same house 1 year & over, percent, 2007-2011	80.8%	84.1%
Foreign born persons, percent, 2007-2011	6.6%	4.5%
Language other than English spoken at home, percent age 5+, 2007-2011	9.3%	6.4%
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Policies and Procedures for Manipulation Under Anesthesia

Robert C. Gordon, D.C., FABCS, FRCCM, DAAPM

Purpose

The purpose of writing these policies and procedures is for facilities or doctors or the staff of a facility to have a guideline for providing the service of the technique of Manipulation Under Anesthesia (MUA). It will be used in conjunction with the National Academy of MUA Physicians standards and protocols, and will be used to determine the types of doctors who may use the facilities for MUA; the educational standards required for staff privileges for the use of MUA; for the patient logistical movement in the facility; the required policy for the use of the MUA procedure; the basis for clinical selection of cases for the MUA procedures; the accepted and suggested follow-up post care requirement for the MUA patients; and for the overall guidelines for the MUA procedures that may not be part of the mentioned areas above.

Educational Standards

It shall be the policy of this facility that the doctors that are performing this procedure must have achieved 36 hours of postgraduate instruction in MUA from a CCE/CME accredited Chiropractic or Medical school, and that those hours contain education in: The history of the MUA procedure; the scientific basis of the MUA procedure; the clinical application of the patients for MUA; the proper selection of the patients for MUA (use of the NAMUAP standards and protocols); two week-ends of education in MUA consisting of a didactic education and workshops, an examination both oral and written, and a second week-end which allows the doctors to be proctored on actual patients with hands on training in the MUA procedure. This standard of education has long been the standard of education for MUA since its inception, and has been taught by the original MUA instructors since the late 80's in the chiropractic profession. Since the MDs and the DOs have no formal MUA program at this time in their institutions most MDs and DOs have been taking their training from the chiropractic profession. There is a preponderance of evidence that the education of the doctors performing this procedure must follow extensive standards that have long been the standard of education to understand the full process of MUA. There is also evidence that if proper education in the area of billing and working with insurance companies is not completed properly there is no proper follow-up for graduating doctors, and therefore no education in the proper use of coding, and fee structures. This should be considered when a doctor becomes a part of a facility. The doctors that use this facility must have an idea of proper billing procedures, and must follow standards that allow for conservative billing practices as taught in the long standing older courses. The older courses still teach proper billing practices and therefore will be used as the gold standard for any doctor that has taken the training.

Proper Patient Selection

It shall be the policy of the facility that the proper selection of patients for this procedure should be foremost in the mind of the practitioner of MUA. Proper selection of the patient is the purest form of proper outcomes, and the essence of a good MUA program is the highest recovery rate possible from those patients selected to undergo MUA. The use of the National Academy of

MUA Physicians is a good start for this section. Other algorithms that follow standard care for various conditions may also be formatted to fit this particular section, and may be included in additional appendixes within this policies and procedures protocols.

Clinical Efficacy of Manipulation Under Anesthesia(MUA)

It has long been the practice of the doctor involved in physical medicine and chiropractic that the movement, mobilization, manipulation, and adjusting of joints, joint capsules, and surrounding holding elements (muscles, ligaments, and tendons) of aberrant articulations can decrease the patients pain and increase range of motion. Literature and reference of all kinds for many years has contended, and research has proven that to relocate abnormal articulations and correct misalignment from biomechanical abnormalities creates an atmosphere of correction and recovery from which patients respond very well. The chiropractic profession, as well as the osteopathic profession, have long stood behind these practices, and the medical profession in most recent years have also given credence to mobilization and manipulation as a real alternative to other frequently used methods of medical pharmacologic intervention or surgery.

Manipulation under anesthesia is a modality which has been used by all of the above mentioned practitioners since the early 30's to bring about the correction of biomechanical abnormalities that would only respond minimally to conservative office based manual therapy in its various forms. The object and therefore the clinical justification for the use of MUA is simply to relax the patient and then make the corrections in the biomechanical abnormality by means of stretching mobilization and manipulation of the articulations that are involved in the abnormal mechanical alteration. If the right anesthesia is introduced in a proper environment that allows the patient to respond, but be less apprehensive and have less discomfort, the practitioner who has MUA certificate training is better able to make corrections such that the patient gains back range of motion and therefore is relieve of neurological stressors that cause painful response while they are being compressed. To make more out of this than this simple statement is complicating a very well received and very well used procedure that causes many recoveries that would not respond if not for this procedure being used.

Clinically we are basically taking arthrokinectic dysfunctional anatomy which is causing fibroblastic proliferative changes (adhesions) to be formed, altering them, and giving back normal movement and in the process decreasing pain and dysfunction.

Patient Selection Criteria

In conjunction with the National Academy of MUA Physicians and following their standards and protocols the following would be indicated but may not be limited to: Following the standards of proper care as outlined by the NAMUAP standards and protocols which calls for a minimum of 4-6 weeks of conservative manual therapy care:

1. The patient must exhibit pain and or muscle spasm/contracture documented by three of the following:
   a. Observation
   b. Palpation

c. Visual analog scale
d. Measurement (algometry)
e. History
f. Objective testing such as MRI, CT, EMG, Surface EMG, Mechanical Dermatomal alteration, or other well established diagnostic testing modalities.
g. Standardized pain questionnaire such as Oswestry or Roland Morris

2. The patient must also be diagnosed as having a primary neuromusculoskeletal complaint as the primary cause of the patients complaint using the standard MUA protocols for MUA patient selection criteria (NAMUAP).

3. The patient's diagnosed condition must interfere with the patient's **activities of daily living** as outlined in the history and physical, and fall within the standard **indications** for MUA, as referenced in: "Manipulation Under Anesthesia, Concepts In Theory and Application", R. Gordon, April 2005, Taylor and Francis, and the NAUMAP standards and protocols.

4. Sufficient care has been rendered prior to MUA selection as referenced above.

5. The patient has been informed of other treatments that might also be available, but has chosen to proceed with the MUA procedure after adequate explanation of the risks and benefits.

Medical Clearance and Standardized Review

Medical clearance is required for MUA just like medical clearance is required for any procedure completed under anesthesia. The requirements for medical clearance vary for each state, and each facility and the anesthesiologists requirements before anesthesia is provided. This determines what the standard testing will be required before the patient undergoes MUA. In general the class one patient will be required to have a physical examination involving all systems, heart, respiratory system, liver, abdomen, eyes nose and throat, and complete musculoskeletal and neurological work up. Blood work that is required is usually minimal (ex. SMAC 6) just to rule out any problems that might prevent excretion of medicines and slow metabolism etc.. Most facilities also require that the patients over 40-50 undergo an EKG, and if respiratory problems are suspected, or asthma, a chest x-ray. Since we only choose patients that fall within the class 1 or with evaluation class 2 anesthesia criteria, these tests are fairly routine in most facilities.

The other requirement is for medical supervision and oversight. Medical presence should be part of the team approach for MUA. It should be remembered that this not a one type of physician procedure. This is a team procedure and cannot be accomplished by one or even two practitioners. We teach in class that this is not a chiropractic procedure but rather a procedure that chiropractic physicians take part in. In order for this procedure to be completed there needs to be a medical clearance physician as mentioned above, there needs to be anesthesia clearance and an anesthesia practitioner involved, there needs to be medial oversight, there needs to be two

trained MUA practitioners to perform the procedure, and there needs to be nursing supervision of the patient during and after the procedure in recovery before the patient is sent home.

Treatment Protocols

1. The following must be considered when considering the treatment and the numbers of treatments necessary to achieve the desired results in the MUA field:

   a. Chronicity
   b. Length of current conservative therapy program
   c. Patients age
   d. Numbers of previous injuries to the same area
   e. Level of unimproved pain
   f. Patient acceptance
   g. Muscle contracture (beyond splinting)
   h. Interference with activities of daily living (ADLs)
   i. Augmentation of adhesion build up, esp. with failed back surgery
   j. Possible surgical intervention if MUA is not tried at this juncture of the patient's recovery. Serial MUA considered to prevent surgery where one procedure might still make the patient a surgical candidate, three or four MUAs might prevent the surgical intervention (ref. NAMUAP).

2. The usual and customary protocols for MUA have been to provide serial fashion MUA, where the procedure is repeated in three successive days. This approach over the years has proven to be very beneficial to the patient, and has been clinically justified by the referenced fact that when correcting adhesion build up, if collagen fibers are not addressed during remodeling in an intensive format, which is what MUA does, then adhesions (or fibroblastic proliferative tissue) begins to reform in 24-48 hours. It is the contention by the MUA community that if we were to allow for one MUA to be performed, and then waited a week to do another one etc., then the process of reformation and remodeling would not take place, but rather the adhesion would reform again. In doing that we would be constantly working to control the reformation of the adhesions that had formed over the period of time since the patient was injured. It has been shown doing MUA in serial fashion and based on the references that performing multiple MUAs and then following the MUAs with immediate post MUA care to be described later in these policies and procedures, that the adhesions do not form back as before as evidenced by the patient gaining considerable range of motion and decreased pain and in many cases an 80 to 90% recovery with the proper patient selection.

3. Post MUA Care – is without a doubt, one of the most important phases of the MUA procedure. With the fibroblastic proliferative tissues altered in an intensified manner, the joints, joint capsules, and the surround holding elements must undergo continuous motion and joint manipulation/adjusting to help reform those collagen fibers in order to maintain the status of improvement that was achieved during the MUA procedure. In the past, post care was carried on in a normal conservative fashion, however, it is now believed that immediate intensified post care consisting of immediate same day therapy using the exact

same stretches that were used during the MUA procedure, followed by 7-10 days of continuous motion, mobilization and manipulation with minimal resistance, followed by 2 weeks of pre-rehabilitation using slight to moderate resistive forces, and then 4 weeks of formal circuit training rehabilitation will give the best outcomes. This regime has been used over and over by the MUA community, and has been found to be the best approach to maintaining the improvement that was achieved during the MUA procedure itself. Since the end result of this procedure is recovery from the conditions that were chosen to receive the MUA procedure, and to maintain the status post recovery, the patient has to undergo changes in their life style, and feel a sense of accomplishment in not only the therapy that was administered using the MUA procedure, but in their own benefit by their participation in the recovery process.

Operative Procedure (this report is a guideline and sample for the full spine procedure referenced in the textbook, "Manipulation Under Anesthesia, Concepts In Theory and Application; R. Gordon....it is not meant to replace standard documentation specifically dictated for each procedure for each day the patient undergoes MUA.) Also note that extra spinal techniques have not been presented but should be dictated for each area treated.

PROCEDURES PERFORMED:

1. Manipulation of the hip joint requiring general anesthesia, **RIGHT & LEFT; CPT 27275 x 2 – 51**
2. Manipulation under anesthesia, shoulder joint, **RIGHT & LEFT; CPT 23700 x 2 – 51**
3. Manipulation of the spine requiring anesthesia, **CERVICAL, THORACIC, & LUMBAR regions; CPT 22505 x 3 – 51**

PRE-OP DIAGNOSIS: **(Example)**

1. Displacement of Thoracic and/or Lumbar IVD without Myelopathy **(ICD-9 722.1)**
2. Displacement of cervical IVD without Myelopathy **(ICD-9 722.0)**
3. Myalgia and Myositis; cervical, thoracic, lumbar, bilateral shoulder/peri-scapular musculature, pelvic girdle musculature, and bilateral hip regions **(ICD-9 729.1)**
4. Spasm of muscle/muscle hypertonicity; cervical, thoracic, lumbar, bilateral shoulder/peri-scapular musculature, pelvic girdle musculature, and bilateral hip regions **(ICD-9 728.85)**

POST-OP DIAGNOSIS:
Same as Pre-op Diagnosis

INFORMED CONSENT:
After adequate explanation of the medical, surgical, and procedural options, this patient has decided to proceed with the recommended spinal Manipulation Under Anesthesia. The patient has been informed that more than one procedure may be necessary to achieve satisfactory results.

INDICATION:
Upon review of the patient's history and supplied medical records the patient has been found a good candidate for manipulation under anesthesia. The standards of protocol being followed are set forth by the National Academy of MUA Physicians.

COMMENTS:
The patient understands the essence of the diagnosis and the reasons for MUA. The associated risks of the procedure, including anesthesia complications, fracture, vascular accident, disc herniation, and post-procedure discomfort, were thoroughly discussed with the patient. Alternatives to the procedure, including the course of the

condition without MUA were discussed. The patient understands the chances of success from undergoing MUA and that no guarantees are made or implied regarding outcome. The patient has given both verbal and written informed consent for the listed procedure.

THE PROCEDURE IN DETAIL:
The patient's pain level today was 8 out of a possible 10 (10 being the worst imaginable pain)
The patient was draped in appropriate gowning and was taken by gurney to the operative area and asked to lie supine on the operative table. The patient was then placed on the appropriate monitors for this procedure. When the patient and I were ready, the anesthesiologist administered the appropriate medications to assist the patient into twilight sedation using medications which allow the stretching, mobilization, and adjustments necessary for the completion of the outcome desired.

THE CERVICAL SPINE:
The patient's arms were crossed and the patient was approached from the rostral end of the table. Long axis traction was applied to the patient's cervical spine and musculature while counter-traction was applied by the co-attending doctor. The co-attending doctor was positioned to stabilize the patient's shoulders in order to use this counter-traction maneuver. Traction in the same manner was then applied into a controlled lateral coronal plane bilaterally, and then in an oblique manner by rotating the patient's head to 45 degrees and elevating the head toward the patient's chest. This was also accomplished bilaterally. At no time was the patient taken past the physiological barrier. The patient's head was then brought into a neutral posture and cervical flexion was achieved to traction the cervical paravertebral muscles. The cervical spine was then taken into a lateral traction maneuver to achieve specific closed reduction manipulation of vertebral elements at the cervical spine on the right side and again using the same technique on the left side of the cervical spine. During this maneuver, a low velocity thrust was achieved after taking the vertebrae slightly past the elastic barrier of resistance. Cavitations were achieved.

SHOULDER THORACIC LIFT:
With the patient in the supine position, the doctor distracts the right arm straight/superior cephalad to end range. This is accomplished on both sides to release thoracic elements before the thoracic adjustment.

SHOULDER:
With the patient in the supine position the doctor stands on the side of involvement. The doctor takes the patient's arm in the bent arm position and tractions up away from the patient's body and tucks the extremity into the doctor's abdominal area. The doctor has contact at the crook of the patient's bent arm and support contact on the patient's lateral shoulder area over the mid deltoid area. In this position, the attending doctor then walks the extremity forward into forward flexion noting range of motion and patient's resistance. Once the extremity and thus the shoulder was taken into forward flexion the next move was to leave the contact hand in place and do an adduction traction over the doctor's hand toward the middle of the patient' body. The next move was then to relocate position so that internal and external ranges of motion are performed. The attending doctor can take the shoulder through simple external and internal ranges of motion on the first day and then become more aggressive on the following days by contacting the upper extremity up near the axial and doing internal and external rotation closer to the body.

The next part of the procedure is the same forward flexion maneuver with the arm straight. Traction is accomplished by contacting the wrist, tucking the arm in close to the doctor, and then walking the arm forward into forward flexion. Then the same adduction move is accomplished with the doctor keeping the arm straight and tractioning the arm over his or her hand toward mid line of the body. Next the doctor stands at the head of the patient and lowers the patient's arm to his side. Forward flexion in then accomplished with a knife edge contact at the acromioclavicular humeral joint area. Traction is made during forward flexion into the knife edge and a slight thrust into the joint is made.

The attending doctor then assumes the forward position and tractions the arm up and away and at the same time rotates his hip into the axillary area. This opens up the joint space and the doctor contacts the lateral border of the clavicle and administers three short toggle thrusts into the area with a pisiform contact. The thrusts are not directed into the clavicle but the line of drive is more toward the lateral clavicle and the medial border of the humerus.

The patient is then placed in the side lying position and circumduction clockwise and counterclockwise is accomplished by contacting the head of the humerus. This maneuver is accomplished by the doctor cupping the hands with interwoven fingers around the head of the humerus and the movements are very small and deliberate.

Once all these maneuvers are accomplished the doctor then completes the A to P manipulative procedure. Contact is at the cephalad border of the pectoralis major with support for the scapula and at the anterior aspect of the humeral glenoid cavity joint. The thrust is a motion that mimics the relocation of the head of the humerus into the glenoid cavity. The movement is up and over the shoulder with respect to line of drive.

THE THORACIC SPINE:
With the patient in the supine position on the operative table, the upper extremities were flexed at the elbow and crossed over the patient's chest to achieve maximum traction to the patient's thoracic spine. The co-attending doctor held the patient's arms in the proper position and assisted in rolling the patient for the adjustive procedure. With the help of the first assistant, the patient was rolled onto their side, selection was made for the contact point and the patient was rolled back over the doctor's hand. The elastic barrier of the resistance was found, and a low velocity thrust was achieved using a specific closed reduction anterior to posterior manipulative procedure. This same procedure was repeated at the upper, middle, and lower thoracic regions.

MEDIAL SCAPULAR BORDER LIFT:
With the patient in the side lying position, the patient's lower arm is moved behind the patient to allow relaxation of the scapular muscles. With the assistance of the co-attending doctor, the attending doctor reaches into the medial scapular area and lifts both vertically and laterally to separate subscapular adhesions.

THE LUMBAR SPINE:
With the patient supine on the procedure table, the primary physician addressed the patient's lower extremities which were elevated alternatively in a straight leg raising manner to until resistance due to adhesions and/or nocioceptive response by the patient. Linear force is used to increase the hip flexion gradually during this maneuver. Simultaneously, the co-attending physician applies a myofacial release technique to the calf and posterior thigh musculature. Each lower extremity was independently bent at the knee and tractioned cephalad in a neutral sagittal plane, lateral oblique cephalad traction, and medial oblique cephalad traction maneuver. The primary physician then approximated the opposite single knee from their position from neutral to medial slightly beyond the elastic barrier of resistance, allowing for a piriformis myofascial release as well. This was repeated with the opposite lower extremity. Following this, a Patrick-Fabere maneuver was performed up to and slightly beyond the elastic barrier of resistance.

PIRIFORMIS BOW-STRING STRETCH:
With the patient in the supine posture and following the adductor stretch, the patient's knee is held slightly past medial and the attending doctor contacts the knee with their hand. The force is applied toward the table with the help of the co-attending doctor and the piriformis muscle is then massaged. The force down the femur into the pelvic basin allows for relaxation of the piriformis muscle across the obturator foramina.

With the co-attending physician stabilizing the pelvis and femoral head, the attending physician extended the right lower extremity in the saggital plane, and while applying controlled traction radically stretched the para-articular holding elements of the right hip by means of gradually describing an approximately 30-35 degree horizontal arc. The lower extremity was then traction straight caudad and internal rotation was accomplished. Using traction, the lower extremity was gradually stretched into a horizontal arch to approximately 30 degrees. This procedure was then repeated using external rotation to stretch the para-articular holding elements of the hips bilaterally. These procedures were then repeated on the opposite lower extremity.

With the patient's lower extremities kept in hip and knee flexion, the patient's torso was secured by the co-attending doctor and the lumbar fasciae and musculature elongated obliquely to the right of mid-line, in a controlled manner up to and beyond the elastic barrier of resistance. Cavitation was noted. This was repeated on the opposite side.

The patient is then repositioned in the supine posture and the same lateral knee movement is repeated bilaterally only this time there is more of a torsion traction movement up toward the head and then laterally away from the main trunk thereby stretching the lumbar holding elements of the spinal motion units. This posture is proving to

show potential disc decompression as evidenced by pre and post MRI studies that have been completed for research purposes.

With the use of under sheets, the patient was carefully placed in the side lying decubitus position and positioned so that the lumbar spine overlay the kidney plate to the point where the lumbar spine attained the horizontal and was de-rotated to avoid facet imbrications.

ILIOPSOAS STRETCH:
With the patient in the side lying position, the upper leg is bent at the knee and distracted in a horizontal manner to stretch the iliopsoas muscle. The leg is then extended more caudad at a 30 degree angle to stretch the TFL.

The patient's body was stabilized by the first assistant. The knee and hip of the upper leg were flexed and the lower leg stabilized in the extended position by the co-attending doctor. Segmental localization of the appropriate lumbar motion-units was made by the attending physician and the elastic barrier of resistance found. A low velocity impulse thrust was applied achieving cavitation. This procedure was then repeated for the sacroiliac joint. The posterior superior iliac spine and lumbar spine was then adjusted on the opposite side with the patient in the same position as above.

The patient was then repositioned supine by means of the under sheets. With appropriate assistance, the patient was transferred from the procedure table to the gurney and was returned to the recovery room, where appropriate monitoring equipment was utilized to monitor vital signs. The IV was maintained up to the point where the patient was fully alert and stable. The patient was then transferred to a sitting recovery position and given fluids and a light snack. Following this, the patient was discharged with appropriate home instructions.

COMPLICATIONS:
The patient tolerated the procedure well with no untoward incident or complication.

SUMMARY:
The patient tolerated the procedure well and without complications and recovered from the general anesthesia without difficulty.

SUMMARY:
The patient underwent MUA of the axial spine and extremities. The patient tolerated the procedure well; there were no intra-operative or post-operative complications. The patient was able to achieve increased motion post MUA without significant muscle guarding. With the improvement of range of motion, it is medically reasonable to opine that this patient's fibro-adhesive conditions were significantly impacted, increasing the potential for appropriate neuromuscular re-education of affected myofacial structures and before having re-establishment of collagen deposition during the healing phase.

PATIENT INSTRUCTIONS:
The patient will receive post MUA therapy, in the doctor's office or P.T. suite to include heating the area of involvement; stretching of the involved areas just as they were stretched during the MUA procedure; followed by interferential in a hertz range of 80-120 and 0-10 with cryotherapy for a duration of no longer than 20 minutes. This will be completed each day after the MUA procedure.

PROGNOSIS:
The patient under went post MUA examination and considering the patient's overall improvement in function and diminishing pain, it is opined, absent further injury, that the patient's prognosis is considered to be good. The patient will continue with the next procedure based on the improvement noticed during the post examination and in keeping with the recommendations of the serial pattern of MUAs as per standing orders. This follows standards and protocols as established by the National Academy of MUA Physicians. The patient has been instructed that periodic exacerbations or remissions may be experienced. These may be adequately managed by means of palliative care and with the recommended post MUA therapy.

Recommendations For Pre and Post Instructions to The MUA Patient

Pre MUA Instructions:

The patient should get a good nights sleep; the patient needs to be NPO 8-12 hours before the procedure due to the administration of anesthesia; the patient should not eat a heavy meal the night before the procedure is completed the following day; medications that are taken normally are usually taken with a sip of water the morning of the procedure (these recommendations are determined by the anesthesiologist in charge of the procedure, i.e for hypertension etc.); the patient must have undergone a medical clearance for anesthesia by an MD or a DO who is familiar with the procedure that is being performed so that an accurate opinion of the patient tolerating the anesthesia is obtained prior to undergoing MUA; the patient **must** have transportation other than themselves from the facility where the procedure is being performed back to their home. No one will be allowed to leave the facility without proper transportation; the patient should be out of work the days that the procedure is being administered. This procedure involves the administration of an anesthesia and the patient should not be signing anything important, making decisions, nor driving any vehicle while they are under the effects of the anesthesia which could affect them most of the day of the procedure.

Post MUA Instructions:

The post MUA instructions are based on what the treating physician wants the patient to do. However, the generalized post MUA instructions consist of returning to a semi-normal to normal diet. By this we mean that on the days of the MUA when a second or third MUA are completed the next day we recommend that a light diet be followed. Once the MUAs have been completed then the patient can return to their normal diet with recommendations from their treating physician. On the days of the procedure, we recommend that the patient be seen at the treating doctor's office later that same day if possible. With late afternoon MUA procedures being completed this is not practical, but when procedures are completed in the morning the patient should return to the office in the afternoon for post MUA care same day. We recommend that ice be used by the patient, and that they follow the instructions of the anesthesiologist, or medical treating doctor as far as post MUA medications. The patient should rest the days of the procedures, and should not being doing anything strenuous. Doing strenuous exercise or movements could cause harm to the patients until given permission to do these types of activities by their treating physician. Again, if the patient is going to undergo the next in a series of MUAs, the patient should be NPO 8-12 hours before the next days MUAs. Over the years we have not had any lingering effects from anesthesia when multiple MUAs are completed on three successive days.

Recommendations For Post MUA Therapy and Rehabilitation

The treating physician is ultimately responsible for the post MUA care. Our recommendation is that since we are attempting, and in most cases accomplishing the altering of adhesions (fibroblastic proliferative collagen tissue) from reforming in and about the joints and holding elements, that continued regular stretching should be started immediately after the MUAs. We recommend that if possible these stretches be the same as during the MUA procedure, and that

they be performed on the same day as the MUA with no manual adjustive therapy. Once the final MUA is completed, we recommend continuing with the stretching process that has already begun, but that now the adjustive techniques also be added. This process should ideally be performed on a daily basis for 7-10 days following the MUA procedures. We then recommend 2 weeks of pre-rehabilitation which would involve the beginning of continued movement with slight resistive strengthening. This is still not the time for conditioning and strengthening, but a time for the patient to start rebuilding the strength that was lost from injury, and from the process of the MUA procedure where weakening occurs as part of the corrections that take place as a result of performing this procedure. This is then followed by between 4 and 6 weeks of formal rehabilitation. It is this part of the post recovery phase of MUA where the patient claims his or her recovery and strengthens the body to return to their normal pre-injury physical capacity and activities of daily living. We recommend circuit training which not only helps the patient regain strength, but is also enjoyable to accomplish. Encouragement for re-strengthening should be foremost on the treating physicians mind at this point so that the patient will want to continue with their fitness program when they are dismissed from formal treatment.

Attachment C.N.5.A

Service Area
Hospital - Pain Management

2009	Co.	I/P	O/P
Centennial Medical Ctr.	Davidson	0	100
St. Thomas Hospital	Davidson	0	0
Skyline Madison Campus	Davidson	13	1,008
Southern Hills Medical Ctr.	Davidson	0	13
Summit Medical Ctr.	Davidson	0	0
Vanderbilt Stallworth Rehab.	Davidson	3	0
Vanderblilt University Hospital	Davidson	25	909
NorthCrest Medical Ctr.	Robertson	0	0
Middle TN Medical Ctr.	Rutherford	0	0
StoneCrest Medical Ctr.	Rutherford	1	66
Total		42	2,096

2010	Co.	I/P	O/P
Centennial Medical Ctr.	Davidson	75	429
St. Thomas Hospital	Davidson	0	0
Skyline Madison Campus	Davidson	7	785
Southern Hills Medical Ctr.	Davidson	0	33
Summit Medical Ctr.	Davidson	0	0
Vanderbilt Stallworth Rehab.	Davidson	0	0
Vanderblilt University Hospital	Davidson	7	1,096
NorthCrest Medical Ctr.	Robertson	0	0
Middle TN Medical Ctr.	Rutherford	0	0
StoneCrest Medical Ctr.	Rutherford	6	162
Total		95	2,505

2011	Co.	I/P	O/P
Centennial Medical Ctr.	Davidson	42	317
St. Thomas Hospital	Davidson	0	24
Skyline Madison Campus	Davidson	0	530
Southern Hills Medical Ctr.	Davidson	0	18
Summit Medical Ctr.	Davidson	0	3
Vanderbilt Stallworth Rehab.	Davidson	0	0
Vanderblilt University Hospital	Davidson	4	1,530
NorthCrest Medical Ctr.	Robertson	0	67
Middle TN Medical Ctr.	Rutherford	0	1
StoneCrest Medical Ctr.	Rutherford	22	433
Total		68	2,923

Source: 2009, 2010 & 2011 JAR, Schedule D - Services

Service Area ASTC's
Pain Management

2012 - Provisional	Co.	ORs	PR	T RM	PM Pts	Total Pts	Pt %	PM Proc	Total Proc	Proc %	Proc./RM
Baptist Ambulatory Surgery Ctr	Davidson	6	1	7	1,178	7,443	15.8%	2,485	15,599	15.9%	2,228
Baptist Plaza Surgicare	Davidson	9	1	10	340	8,215	4.1%	691	17,641	3.9%	1,764
Centennial Surgery Ctr	Davidson	6	2	8	1,569	7,491	20.9%	3,430	13,914	24.7%	1,739
Northridge Surgery Ctr	Davidson	5	2	7	296	2,863	10.3%	652	6,928	9.4%	990
Premier Orthopaedic Surgery Ctr	Davidson	2	0	2	143	2,277	6.3%	287	4,443	6.5%	2,222
Premier Radiology Pain Management Ctr	Davidson	0	2	2	1,957	1,957	100.0%	6,327	6,327	100.0%	3,164
St. Thomas Campus Surgicare	Davidson	6	1	7	1,624	7,446	21.8%	3,589	17,910	20.0%	2,559
St. Thomas Outpatient Neurosurgical Ctr	Davidson	2	1	3	2,530	2,530	100.0%	5,465	5,465	100.0%	1,822
Summit Surgery Ctr	Davidson	5	1	6	1,057	5,445	19.4%	2,313	12,534	18.5%	2,089
Tennessee Pain Surgery Ctr	Davidson	1	3	4	2,847	2,847	100.0%	8,960	8,960	100.0%	2,240
Middle Tennessee ASTC	Rutherford	6	1	7	597	6,490	9.2%	1,918	12,708	15.1%	1,815
Physicians Pavilion Surgery Ctr	Rutherford	4	1	5	833	2,864	29.1%	1,861	5,314	35.0%	1,063
Surgicenter of Murfreesboro Med. Clinic	Rutherford	*	*	*	*	*	*	*	*	*	*
ASTC of Cool Springs	Williamson	5	1	6	370	7,292	5.1%	785	11,066	7.1%	1,844
Crossroads Surgery Ctr	Williamson	0	2	2	432	432	100.0%	4,419	4,419	100.0%	2,210
Williamson Surgery Ctr	Williamson	*	*	*	*	*	*	*	*	*	*
Total		57	19	76	15,773	65,592	24.0%	43,182	143,228	30.1%	1,885

Legend : ORs = Number of Operating Rooms
PRs = Number of Procedure Rooms
T RM = Total Number of Operating Rooms plus Procedure Rooms
PM Pts = Number of Pain Management Patients
Total Pts = Total Number of patients seen during year
Pt % = Pain Management patients as a Percentage of Total patients
Proc = Number of Pain Management Procedures
Total Proc. = Total Number of Procedures Performed during year
Proc % = Pain Management Procedures as a Percentage of Total Procedures
Proc/RM = Total Proc. / T RM

* No JAR

Source: 2012 Provisional JAR, Schedule D - Availability and Utilization of Service

Attachment C.N.5.B

Service Area ASTC's
Pain Management

2011	Co.	ORs	PR	T RM	PM Pts	Total Pts	Pt %	PM Proc	Total Proc	Proc %	Proc./RM
Baptist Ambulatory Surgery Ctr	Davidson	6	1	7	1,098	7,304	15.0%	2,352	16,059	14.6%	2,294
Baptist Plaza Surgicare	Davidson	9	1	10	568	9,171	6.2%	1,161	21,635	5.4%	2,164
Centennial Surgery Ctr	Davidson	6	2	8	1,556	7,405	21.0%	3,625	13,486	26.9%	1,686
Northridge Surgery Ctr	Davidson	4	2	6	273	3,201	8.5%	8,318	16,416	50.7%	2,736
Premier Orthopaedic Surgery Ctr	Davidson	2	0	2	974	2,382	40.9%	2,400	5,122	46.9%	2,561
Premier Radiology Pain Management Ctr	Davidson	0	2	2	2,000	2,000	100.0%	6,701	6,701	100.0%	3,351
St. Thomas Campus Surgicare	Davidson	6	1	7	1,721	7,639	22.5%	6,439	25,441	25.3%	3,634
St. Thomas Outpatient Neurosurgical Ctr	Davidson	2	1	3	2,469	2,469	100.0%	5,544	5,544	100.0%	1,848
Summit Surgery Ctr	Davidson	5	1	6	1,672	6,505	25.7%	4,306	14,112	30.5%	2,352
Tennessee Pain Surgery Ctr	Davidson	1	3	4	3,316	3,316	100.0%	7,848	7,848	100.0%	1,962
Middle Tennessee ASTC	Rutherford	6	1	7	464	6,264	7.4%	1,570	12,644	12.4%	1,806
Physicians Pavilion Surgery Ctr	Rutherford	4	1	5	752	2,976	25.3%	1,616	5,781	28.0%	1,156
Surgicenter of Murfreesboro Med. Clinic	Rutherford	*	*	*	*	*	*	*	*	*	*
Cool Springs Surgery Ctr	Williamson	5	1	6	12	6,501	0.2%	26	10,841	0.2%	1,807
Crossroads Surgery Ctr	Williamson	0	1	1	275	275	100.0%	720	720	100.0%	720
Williamson Surgery Ctr	Williamson	4	1	5	6	3,410	0.2%	6	6,443	0.1%	1,289
Total		60	19	79	17,156	70,818	24.2%	52,632	168,793	31.2%	2,137

Legend : ORs = Number of Operating Rooms
PRs = Number of Procedure Rooms
T RM = Total Number of Operating Rooms plus Procedure Rooms
PM Pts = Number of Pain Management Patients
Total Pts = Total Number of patients seen during year
Pt % = Pain Management patients as a Percentage of Total patients
Proc = Number of Pain Management Procedures
Total Proc. = Total Number of Procedures Performed during year
Proc % = Pain Management Procedures as a Percentage of Total Procedures
Proc/RM = Total Proc. / T RM

* No JAR

Source: 2011 JAR, Schedule D - Availability and Utilization of Service

Service Area ASTC's
Pain Management

2010	Co.	ORs	PR	T RM	PM Pts	Total Pts	Pt %	PM Proc	Total Proc	Proc %	Proc./RM
Baptist Ambulatory Surgery Ctr	Davidson	6	1	7	1,077	7,472	14.4%	2,208	12,709	17.4%	1,816
Baptist Plaza Surgicare	Davidson	9	1	10	942	9,427	10.0%	2,619	23,104	11.3%	2,310
Centennial Surgery Ctr	Davidson	6	2	8	1,116	7,217	15.5%	2,930	13,403	21.9%	1,675
Northridge Surgery Ctr	Davidson	4	1	5	654	3,673	17.8%	1,782	9,599	18.6%	1,920
Premier Orthopaedic Surgery Ctr	Davidson	2	0	2	681	2,104	32.4%	1,746	4,377	39.9%	2,189
Premier Radiology Pain Management Ctr	Davidson	0	2	2	1,666	1,666	100.0%	5,839	5,839	100.0%	2,920
St. Thomas Campus Surgicare	Davidson	6	1	7	1,459	6,835	21.3%	6,122	19,479	31.4%	2,783
St. Thomas Outpatient Neurosurgical Ctr	Davidson	2	2	4	2,523	2,523	100.0%	5,481	5,481	100.0%	1,370
Summit Surgery Ctr	Davidson	5	1	6	2,267	6,873	33.0%	4,764	13,277	35.9%	2,213
Tennessee Pain Surgery Ctr	Davidson	1	3	4	2,305	2,305	100.0%	7,294	7,294	100.0%	1,824
Middle Tennessee ASTC	Rutherford	6	1	7	437	6,244	7.0%	1,465	12,607	11.6%	1,801
Physicians Pavilion Surgery Ctr	Rutherford	4	1	5	922	3,243	28.4%	2,101	6,561	32.0%	1,312
Surgicenter of Murfreesboro Med. Clinic	Rutherford	4	3	7	9	7,468	0.1%	153	10,124	1.5%	1,446
Cool Springs Surgery Ctr	Williamson	5	1	6	233	6,790	3.4%	493	11,114	4.4%	1,852
Crossroads Surgery Ctr	Williamson	0	1	1	220	220	100.0%	500	500	100.0%	500
Williamson Surgery Ctr	Williamson	4	1	5	1	3,531	0.0%	1	4,417	0.0%	883
Total		64	22	86	16,512	77,591	21.3%	45,498	159,885	28.5%	1,859

Legend : ORs = Number of Operating Rooms
PRs = Number of Procedure Rooms
T RM = Total Number of Operating Rooms plus Procedure Rooms
PM Pts = Number of Pain Management Patients
Total Pts = Total Number of patients seen during year
Pt % = Pain Management patients as a Percentage of Total patients
Proc = Number of Pain Management Procedures
Total Proc. = Total Number of Procedures Performed during year
Proc % = Pain Management Procedures as a Percentage of Total Procedures
Proc/RM = Total Proc. / T RM

* No JAR

Source: 2010 JAR, Schedule D - Availability and Utilization of Service

Service Area ASTC's
Pain Management Charges

2010	Co.	Gross $	Net $	#Pts	Gross $/Pt	Net $/Pt	#Procs	Gross $/Proc	Net $/Proc
Premier Radiology Pain Management	Davidson	$3,179,983	$2,163,383	1,666	$1,909	$1,299	2,751	$1,156	$786
St. Thomas Outpatient Neurosurgical	Davidson	$5,849,686	$2,615,321	2,523	$2,319	$1,037	2,523	$2,319	$1,037
Tennessee Pain Surgery	Davidson	$14,277,365	$3,072,102	2,305	$6,194	$1,333	7,294	$1,957	$421
Crossroads Surgery	Williamsor	$590,000	$207,350	220	$2,682	$943	500	$1,180	$415
Total		$23,897,034	$8,058,156	6,714	$3,559	$1,200	13,068	$1,829	$617

2011	Co.	Gross $	Net $	#Pts	Gross $/Pt	Net $/Pt	#Procs	Gross $/Proc	Net $/Proc
Premier Radiology Pain Management	Davidson	$3,680,792	$1,184,882	$2,000	$1,840	$592	3,282	$1,122	$361
St. Thomas Outpatient Neurosurgical	Davidson	$5,811,928	$2,473,977	$2,469	$2,354	$1,002	5,544	$1,048	$446
Tennessee Pain Surgery	Davidson	$13,137,957	$5,378,167	$3,316	$3,962	$1,622	7,848	$1,674	$685
Crossroads Surgery	Williamsor	$331,500	$103,089	$116	$2,858	$889	1,560	$213	$66
Total		$22,962,177	$9,140,115	$7,901	$2,906	$1,157	18,234	$1,259	$501

2012 - Provisional	Co.	Gross $	Net $	#Pts	Gross $/Pt	Net $/Pt	#Procs	Gross $/Proc	Net $/Proc
Premier Radiology Pain Management	Davidson	$6,171,671	$1,520,976	1,957	$3,154	$777	3,196	$1,931	$476
St. Thomas Outpatient Neurosurgical	Davidson	$5,457,807	$2,291,681	2,530	$2,157	$906	5,465	$999	$419
Tennessee Pain Surgery	Davidson	$14,637,835	$5,604,720	2,847	$5,141	$1,969	8,960	$1,634	$626
Crossroads Surgery	Williamsor	$1,518,879	$286,422	432	$3,516	$663	4,419	$344	$65
Total		$27,786,192	$9,703,799	7,766	$3,578	$1,250	22,040	$1,261	$440

Source: 2010,2012 & 2012(Provisional) JAR, Schedule D - Availability and Utilization of Service & Schedule F - Finacial Data

Attachment C.N.5.C

3:29 PM
02/05/13
Accrual Basis

MUA OF MIDDLE TENNESSEE LLC
Balance Sheet
As of December 31, 2012

	Dec 31, 12
ASSETS	
Current Assets	
Checking/Savings	
102 · First Farmers - Checking	506.56
103 · First Tennessee Bank	13,228.02
Total Checking/Savings	13,734.58
Other Current Assets	
140 · A/R Trade	304,457.37
141 · Less Allowance for Discounts	-219,209.31
Total Other Current Assets	85,248.06
Total Current Assets	98,982.64
Fixed Assets	
150 · Furniture and Fixtures	14,130.12
155 · Machinery and Equipment	128,669.00
157 · Leasehold Improvements	82,859.00
161 · Accumulated Depreciation	-153,798.00
Total Fixed Assets	71,860.12
TOTAL ASSETS	170,842.76
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Other Current Liabilities	
208 · Note Payable - A. Douglas Lensg	48,113.25
209 · Note Payable - Faye Smith	3,500.00
210 · Note Payable - Tn Spine	63,382.67
Total Other Current Liabilities	114,995.92
Total Current Liabilities	114,995.92
Total Liabilities	114,995.92
Equity	
304 · Terry Totty - Equity	24,401.99
306 · Lance Benedict - Equity	24,401.98
310 · Paul Yim - Equity	200,000.00
312 · Brett Babat - Equity	100,000.00
320 · Retained Earnings	-158,822.69
Net Income	-134,134.44
Total Equity	55,846.84
TOTAL LIABILITIES & EQUITY	170,842.76

3:29 PM
02/05/13
Accrual Basis

MUA OF MIDDLE TENNESSEE LLC
Profit & Loss
January through December 2012

	Jan - Dec 12
Ordinary Income/Expense	
Income	
350 · Fee for Service Income	779,273.42
352 · Returns and allowances	-200.00
353 · Less Contractual Discounts	-631,643.35
Total Income	147,430.07
Expense	
420 · Medical Records and Supplies	3,571.35
450 · Medical Safety Inspection	382.38
500 · Subcontractor	1,761.00
610 · Automobile Expense	1,055.00
612 · Background Verification	313.95
615 · Bank and Credit Card Charges	1,815.30
620 · Continuing Education	2,975.00
623 · Computer expenses	2,371.92
630 · Depreciation Expense	44,031.00
632 · Design/Planning	28,688.00
633 · EHR Support	7,922.47
635 · Janitorial Expense	1,920.00
638 · Employee Expense	84.93
639 · Insurance Expense	
640 · General Liability	500.00
643 · Malpractice	2,531.53
Total 639 · Insurance Expense	3,031.53
660 · Professional Fees	8,743.24
670 · Office Supplies	1,262.67
675 · Payroll Expenses	
676 · Office Employee	35,901.63
675 · Payroll Expenses - Other	37,196.60
Total 675 · Payroll Expenses	73,098.23
680 · Rent Expense	
681 · Rent - Building	20,966.22
682 · Rent - Equipment	29,485.00
680 · Rent Expense - Other	45,272.45
Total 680 · Rent Expense	95,723.67
705 · Taxes and Licenses	2,275.00
710 · Telephone Expense	537.87
Total Expense	281,564.51
Net Ordinary Income	-134,134.44
Net Income	-134,134.44

C6590

PATIENT TRANSFER AGREEMENT

THIS PATIENT TRANSFER AGREEMENT (this "Agreement") is made as of February 3, 2012, by and between St. Thomas Hospital ("Hospital") and MUA of Middle Tennessee, LLC ("Transferor").

RECITALS:

A. Hospital and Transferor each operate health care entities located in Middle Tennessee.

B. The parties desire to assure a continuity of care and appropriate medical treatment for the needs of each patient in their respective facilities, and have determined that, in the interest of patient care, the parties should enter into an agreement to provide for the transfer of patients from Transferor to Hospital on the terms and conditions set forth herein.

NOW THEREFORE, in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties hereto agree as follows.

1. Term and Termination.

(a) The Agreement shall have a two (2) year term commencing on February 3, 2012 (the "Initial Term"). Upon the expiration of the Initial Term, this Agreement shall automatically renew for up to three additional one-year renewal terms ("Renewal Term") unless either party provides written notice of its intent not to renew to the other party at least sixty (60) days prior to the end of the then current term (the Initial Term and any Renewal Terms are collectively referred to herein as the "Term").

(b) This Agreement may be terminated by either party:

(i) upon ninety (90) days prior written notice to the other party, or

(ii) immediately should the other party fail to maintain the licenses, certifications or accreditations, including Medicare certification, required to operate its facility as it is currently being operated.

2. Transfer.

(a) Upon such time that a patient's physician determines that the patient needs to be transferred from Transferor to Hospital pursuant to Transferor's physician's order, Hospital agrees to admit the patient as promptly as possible and provide healthcare services as necessary, provided all conditions of eligibility are met. Transferor agrees to send the following with each patient at the time of transfer, or as soon thereafter as possible in emergency situations:

(i) an abstract of pertinent medical and other information necessary to continue the patient's treatment without interruption; and

Disabilities Act of 1990, and Title VI of the Civil Rights Act of 1964 each party hereto will not discriminate on the basis of race, sex, religion, color, national or ethnic origin, age, disability, or military service, AIDS and AIDS related conditions in its administration of its policies, including admissions policies, employment, or program activities.

7. Record Availability. Transferor agrees that, until the expiration of four (4) years after the furnishing of any goods and services pursuant to this Agreement, it will make available, upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives, copies of this Agreement and any books, documents, records and other data of Transferor that are necessary to certify the nature and extent of the costs incurred by Hospital in purchasing such goods and services. If Transferor carries out any of its duties under this Agreement through a subcontract with a related organization involving a value or cost of ten thousand dollars ($10,000) or more over a twelve-month period, Transferor will cause such subcontract to contain a clause to the effect that, until the expiration of four (4) years after the furnishing of any good or service pursuant to said contract, the related organization will make available upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives, copies of this Agreement and any books, documents, records and other data of said related organization that are necessary to certify the nature and extent of costs incurred by Transferor for such goods or services. Transferor shall give Hospital notice immediately upon receipt of any request from the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives for disclosure of such information.

Transferor agrees to indemnify, defend and hold Hospital harmless from and against any loss, liability, judgment, penalty, fine, damages (including punitive and/or compounded damages), costs (including reasonable attorneys' fees and expenses) suffered or incurred by Hospital as a result of, in connection with, or arising from Transferor 's failure to comply with this Section 6.

8. Exclusion from Federal Health Care Programs. Transferor represents and warrants that it has not been nor is it about to be excluded from participation in any Federal Healthcare Program. Transferor agrees to notify Hospital within one (1) business day of Transferor's receipt of a notice of intent to exclude or actual notice of exclusion from any such program. The listing of Transferor or any Transferor-owned subsidiary on the Office of Inspector General's exclusion list (OIG website) or the General Services Administration's Lists of Parties Excluded from Federal Procurement and Nonprocurement Programs (GSA website) for excluded individuals and entities shall constitute "exclusion" for purposes of this paragraph. In the event that Transferor is excluded from any Federal Healthcare Program, this Agreement shall immediately terminate. For the purposes of this paragraph, the term "Federal Healthcare Program" means the Medicare program, the Medicaid program, the Maternal and Child Health Services Block Grant program, the Block Grants for State for Social Services program, any state Children's Health Insurance program, or any similar program. Further, Transferor agrees to indemnify and hold Hospital harmless from and against any loss, liability, judgment, penalty, fine, damages (including punitive and/or compounded damages), costs (including reasonable attorneys' fees and expenses) incurred by Hospital as a result of Transferor's failure to notify the Hospital of its exclusion from any Federal Healthcare Program.

this Agreement or any provision of this Agreement, except such rights as shall inure to a successor or permitted assignee pursuant to this paragraph.

(g) In the event that any legal action or other proceedings, including arbitration, is brought for the enforcement of this Agreement or because of an alleged dispute of breach, the prevailing party shall be awarded its costs of suit and reasonable attorney's fees.

(h) All notices, consents, waivers and other communications required or permitted by this Agreement shall be in writing and shall be deemed given to a party when (a) delivered to the appropriate address by hand or by nationally recognized overnight courier service (costs prepaid); or (b) received or rejected by the addressee, if sent by certified mail, return receipt requested, in each case to the following addresses and marked to the attention of the person (by name or title) designated below (or to such other address or person as a party may designate by notice to the other parties):

If to Hospital:	St. Thomas Hospital 4220 Harding Road Nashville, TN 37205
With a copy to:	Saint Thomas Health 102 Woodmont Blvd., Suite 800 Nashville, TN 37205 Attn: Contract Administrator
If to Transferor:	MUA of Middle Tennessee, LLC 28 White Bridge Rd., Suite 210 Nashville, TN 37205

(i) The headings of the various sections of this Agreement are inserted merely for convenience and do not expressly or by implication limit, define or extend the specific terms of the sections so designated. Any rule of construction or interpretation otherwise requiring this Agreement to be construed or interpreted against any party shall not apply to any construction or interpretation hereof.

(j) This Agreement may be executed in one or more counterparts, each of which will be deemed to be an original copy of this Agreement and all of which, when taken together, will be deemed to constitute one and the same agreement. The exchange of copies of this Agreement and of signature pages by facsimile transmission shall constitute effective execution and delivery of this Agreement as to the parties and may be used in lieu of the original Agreement for all purposes. Signatures of the parties transmitted by facsimile shall be deemed to be their original signatures for all purposes.

Attachment C.OD.3

TENNESSEE OCCUPATIONAL WAGES

Total all industries

Nashville-Davidson--Murfreesboro, TN MSA, Tennessee

Healthcare Practitioners and Technical Occupations

Occupation	Occ. code	Est. empl.	Mean wage	Entry wage	Exp. wage	25th pct	Median wage	75th pct
HEALTHCARE PRACTITIONERS AND TECHNICAL OCCUPATIONS	29-0000	N/A	N/A N/A	N/A N/A	N/A N/A	N/A N/A	N/A N/A	N/A N/A
Chiropractors	29-1011	N/A	94,950 45.65	54,690 26.30	115,090 55.35	57,610 27.70	104,920 50.45	115,500 55.55
Dentists, General	29-1021	N/A	147,050 70.70	87,070 41.85	177,040 85.10	95,650 46.00	131,140 63.05	166,080 79.85
Dietitians and Nutritionists	29-1031	270	47,810 23.00	32,350 15.55	55,540 26.70	38,040 18.30	46,150 22.20	59,320 28.50
Optometrists	29-1041	N/A	113,180 54.40	84,320 40.55	127,620 61.35	99,330 47.75	123,270 59.25	136,430 65.60
Pharmacists	29-1051	1,600	115,790 55.65	87,920 42.25	129,720 62.35	101,650 48.85	114,290 54.95	130,650 62.80
Family and General Practitioners	29-1062	N/A	199,290 95.80	120,290 57.85	238,790 114.80	132,700 63.80	>$145,600 >$70	>$145,600 >$70
Internists, General	29-1063	50	170,570 82.00	104,620 50.30	203,550 97.85	121,710 58.50	144,300 69.35	>$145,600 >$70
Obstetricians and Gynecologists	29-1064	100	209,600 100.75	144,220 69.35	242,290 116.50	160,240 77.05	>$145,600 >$70	>$145,600 >$70
Pediatricians, General	29-1065	160	164,340 79.00	93,000 44.70	200,010 96.15	106,070 51.00	148,640 71.45	>$145,600 >$70
Psychiatrists	29-1066	60	184,820 88.85	120,740 58.05	216,860 104.25	149,160 71.70	173,510 83.40	>$145,600 >$70
Surgeons	29-1067	100	N/A N/A	N/A N/A	N/A N/A	N/A N/A	N/A N/A	N/A N/A
Physicians and Surgeons, All Other	29-1069	1,340	232,230 111.65	178,030 85.60	>$145,600 >$70	>$145,600 >$70	>$145,600 >$70	>$145,600 >$70
Physician Assistants	29-1071	520	93,760 45.10	71,020 34.15	105,130 50.55	77,290 37.15	96,210 46.25	111,460 53.60
Podiatrists	29-1081	20	112,510 54.10	66,580 32.00	135,470 65.15	66,170 31.80	72,540 34.85	147,850 71.10
Registered Nurses	29-1111	14,000	64,460 31.00	44,830 21.55	74,280 35.70	49,170 23.65	60,060 28.90	72,320 34.75
Occupational Therapists	29-1122	650	71,540 34.40	61,980 29.80	76,310 36.70	64,590 31.05	70,930 34.10	77,290 37.15
Physical Therapists	29-1123	1,410	73,040 35.10	54,610 26.25	82,250 39.55	61,530 29.60	75,730 36.40	86,910 41.80
Radiation Therapists	29-1124	40	68,380 32.90	50,460 24.25	77,340 37.20	55,390 26.65	66,310 31.90	78,700 37.85

Recreational Therapists	29-1125	150	37,780	27,210	43,070	30,560	35,620	42,390
			18.15	13.10	20.70	14.70	17.10	20.40
Respiratory Therapists	29-1126	610	49,180	38,490	54,520	41,580	50,180	56,990
			23.65	18.50	26.20	20.00	24.15	27.40
Speech-Language Pathologists	29-1127	540	52,980	38,200	60,370	41,150	51,020	60,700
			25.45	18.35	29.00	19.80	24.55	29.20
Exercise Physiologists	29-1128	N/A	49,020	34,100	56,470	36,110	44,220	58,890
			23.55	16.40	27.15	17.35	21.25	28.30
Veterinarians	29-1131	290	107,500	62,510	130,000	69,760	82,010	93,340
			51.70	30.05	62.50	33.55	39.45	44.85
Audiologists	29-1181	N/A	56,400	50,700	59,250	51,010	55,230	59,460
			27.10	24.40	28.50	24.50	26.55	28.60
Health Diagnosing and Treating Practitioners, All Other	29-1199	60	78,010	51,150	91,430	52,990	58,520	80,210
			37.50	24.60	43.95	25.50	28.15	38.55
Medical and Clinical Laboratory Technicians	29-2012	1,920	33,850	24,530	38,500	26,820	32,160	40,020
			16.25	11.80	18.50	12.90	15.45	19.25
Dental Hygienists	29-2021	990	64,760	55,340	69,470	62,320	67,470	72,630
			31.15	26.60	33.40	29.95	32.45	34.90
Diagnostic Medical Sonographers	29-2032	150	63,660	50,950	70,020	54,200	63,690	72,670
			30.60	24.50	33.65	26.05	30.60	34.95
Nuclear Medicine Technologists	29-2033	70	62,500	50,950	68,270	54,510	63,750	70,960
			30.05	24.50	32.80	26.20	30.65	34.10

Entry and Experienced wages represent the mean of the lower third and the mean of the upper two-thirds of the wage distribution respectively. The OES survey does not collect information for entry or experienced workers. Tennessee Department of Labor & Workforce Development, Employment Security Division, Labor Market Information. Publish date May 2012.

TENNESSEE OCCUPATIONAL WAGES

Total all industries

Nashville-Davidson--Murfreesboro, TN MSA, Tennessee

Healthcare Support Occupations

Occupation	Occ. code	Est. empl.	Mean wage	Entry wage	Exp. wage	25th pct	Median wage	75th pct
HEALTHCARE SUPPORT OCCUPATIONS	31-0000	N/A	N/A	N/A	N/A	N/A	N/A	N/A
			N/A	N/A	N/A	N/A	N/A	N/A
Home Health Aides	31-1011	4,190	19,550	16,770	20,950	17,300	19,380	22,080
			9.40	8.05	10.05	8.30	9.30	10.60
Nursing Aides, Orderlies, and Attendants	31-1012	5,780	23,830	19,270	26,100	20,380	22,840	26,820
			11.45	9.25	12.55	9.80	11.00	12.90
Psychiatric Aides	31-1013	630	22,720	18,100	25,040	19,330	22,270	25,780
			10.90	8.70	12.05	9.30	10.70	12.40
Occupational Therapist Assistants	31-2011	N/A	50,700	41,090	55,500	42,350	47,490	59,870
			24.35	19.75	26.70	20.35	22.85	28.80
Physical Therapist Assistants	31-2021	590	48,480	34,690	55,370	41,600	49,070	58,000
			23.30	16.70	26.60	20.00	23.60	27.90
Physical Therapist Aides	31-2022	N/A	23,590	18,190	26,280	19,690	22,700	27,370
			11.35	8.75	12.65	9.45	10.90	13.15
Massage Therapists	31-9011	250	38,120	28,670	42,850	31,010	34,760	41,750
			18.35	13.80	20.60	14.90	16.70	20.05
Dental Assistants	31-9091	1,580	36,650	29,360	40,300	31,780	36,420	42,160
			17.60	14.10	19.35	15.30	17.50	20.25
Medical Assistants	31-9092	3,090	30,650	24,260	33,840	25,820	29,640	35,310
			14.75	11.65	16.25	12.40	14.25	17.00
Medical Equipment Preparers	31-9093	60	31,030	25,350	33,860	26,460	30,660	35,230
			14.90	12.20	16.30	12.70	14.75	16.95
Medical Transcriptionists	31-9094	630	41,380	28,710	47,710	31,110	35,070	40,730
			19.90	13.80	22.95	14.95	16.85	19.60
Pharmacy Aides	31-9095	290	18,500	16,650	19,420	16,750	18,280	20,640
			8.90	8.00	9.35	8.05	8.80	9.95
Veterinary Assistants and Laboratory Animal Caretakers	31-9096	510	22,070	17,060	24,570	18,200	21,240	24,410
			10.60	8.20	11.80	8.75	10.20	11.75
Healthcare Support Workers, All Other*	31-9799	1,070	31,200	23,340	35,140	24,980	30,410	36,380
			15.00	11.20	16.90	12.00	14.60	17.50

Entry and Experienced wages represent the mean of the lower third and the mean of the upper two-thirds of the wage distribution respectively. The OES survey does not collect information for entry or experienced workers. Tennessee Department of Labor & Workforce Development, Employment Security Division, Labor Market Information. Publish date May 2012.

Board for Licensing Health Care Facilities

State of Tennessee

License No. 0000000214

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

MUA OF MIDDLE TENNESSEE, LLC *to conduct and maintain*

an Ambulatory Surgical Treatment Center MUA OF MIDDLE TENNESSEE, LLC

Located at 28 WHITE BRIDGE RD., SUITE 210, NASHVILLE

County of DAVIDSON *, Tennessee.*

This license shall expire FEBRUARY 28 , 2014 , *and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 28TH *day of* FEBRUARY , 2013 .

In the Specialty(ies) of: OTHER

By Vincent J. Dargan, MPH
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By [signature]
COMMISSIONER

Attachment C.OD.7(c)

Attachment C.OD.7(d)

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FACILITIES
WEST TENNESSEE REGIONAL OFFICE
2975 Highway 45 Bypass, Suite C
Jackson, Tennessee 38305
Telephone: (731) 984-9684
Fax: (731) 512-0063

March 06, 2012

Ms. Faye Smith, Administrator
MUA of Middle Tennessee, LLC
28 White Bridge Road, Suite 210
Nashville, TN 37205

RE: Initial Licensure Survey

Dear Ms. Smith:

The West Tennessee Regional Office of Health Care Facilities conducted an initial state licensure survey at your facility **February 07, 2012.** We are pleased to inform you that **no deficiencies were cited** on the survey. A copy of the results is enclosed for your records.

Thank you for your cooperation shown during the survey. If we may be of assistance to you, please do not hesitate to call.

Sincerely,

Diane Carter/rm

Diane Carter, RN, LNCC
Public Health Nurse Consultant II

PDC/rm

Enclosure

PUBLIC CHAPTER NO. 0817

This public chapter amends T.C.A. Titles 38, 39, 63, and 68 to require health care providers to report injuries appearing to result from female genital mutilation. Effective 7/1/12.

PUBLIC CHAPTER NO. 0915

This public chapter amends Titles 39, 53, 63, and 71 to authorize hospital quality improvement committees to access the controlled substances database if suspect an employee of self-prescribing medications. Effective 6/12/12.

PUBLIC CHAPTER NO. 0916

This public chapter amends T.C.A. Titles 63 and 68 enacting the "The Henry Granju Act", to create reporting requirements by provider and Medical Examiners relate to drug overdoses. Effective 5/10/12.

PUBLIC CHAPTER NO. 1008

This public chapter amends T.C.A. Titles 37 and 39 and Title 38, Chapter 11 prohibiting physicians from performing abortions without admitting privileges at a local hospital. In addition, the public chapter requires physicians to notify patient of where the physician has privileges. It also requires a monthly report to the Tennessee Department of Health of each abortion by the facility and where the abortion was performed and signed by the physician who performed the abortion. The public chapter requires the Tennessee Department of Health to annually report to the General Assembly aggregate data from the monthly reports. The public chapter stipulates report requirements. It also requires, in addition to other penalties, that any person, organization or facility convicted of willfully violating any of the provisions of this section to have its license suspended for six months for the first violation, one year for the second violation, and revoked for the third violation. Effective 7/1/12.

PUBLIC CHAPTER NO. 1093

This public chapter amends T.C.A. Titles 36 and 38 which removes the requirement that providers report certain injuries to law enforcement if victim objects. Effective 5/21/12.

DISCIPLINARY ACTION 2012

The board took action against the following licensed health care facilities:

FEBRUARY 2012

Licensee: East Tennessee Health Care Center, Madisonville – nursing home
Violation: Deficiencies cited rising to the level of a Type A civil penalty
Action: Assessment of civil penalty in the amount of $3,600.00 and suspension of admissions

MARCH 2012

Licensee: Bristol Nursing Home, Bristol – nursing home
Violation: Deficiencies cited rising to the level of a Type A civil penalty
Action: Assessment of civil penalty in the amount of $2,700.00 and suspension of admissions

MAY 2012

Licensee: Schilling Gardens, Collierville – assisted care living facility
Violation: Deficiencies cited rising to the level of civil penalty imposition
Action: Assessment of civil penalty in the amount of $2,000.00

Licensee: Kennington Pointe, Memphis – assisted care living facility
Violation: Deficiencies cited rising to the level of civil penalty imposition
Action: Assessment of civil penalty in the amount of $7,500.00

DEFICIENCY FREE SURVEYS

FEBRUARY 2012

AMBULATORY SURGICAL TREATMENT CENTER PROVIDERS:
MUA of Middle Tennessee, LLC
Physician's Surgery Center of Chattanooga

HOME MEDICAL EQUIPMENT PROVIDERS:
Advanced Diabetic Solutions
Medical Necessities, Inc.
Advantage Healthcare
American Home Patient, Inc.
American Oxygen Home Care
Anderson Drugs & Home Care Center
Bradley Medical Equipment
Carr Rehab, Inc.
Cherokee Medical Supply
Convalescent Supplies
Little Drugs
Lookout Medical Services, Inc.
Nutritional Support Services
Ophello Medical Equipment
Oxygen & Sleep Associates
RGH Enterprises, Inc.
Specialty Oxygen Service, Inc.
Tri-State Respiratory Service, Inc.

ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

September 17, 2012

Organization #:	**98360**
Organization:	**MUA of Middle Tennessee, LLC**
Address:	**28 White Bridge Road, Suite 210**
City, State, Zip:	**Nashville, TN 37205**
Decision Recipient:	**Deanna Smith**
Survey Date:	**August 7, 2012**

Type of Survey: **Early Option Survey**

Survey Chairperson: **Marjorie E. Vincent, RN, MBA, CASC**

Accreditation Term Begins: **August 7, 2012** **Accreditation Term Expires:** **August 7, 2015**

Plan for Improvement Submitted: August 29, 2012
Interim Survey by Date: August 7, 2013 Interim Survey Type: Full Survey

Scheduling Coordinator: Leah Peters

Accreditation Renewal Code: **11756bd498360**

Granting accreditation reflects confidence, based on evidence from this recent survey that you meet, and will continue to demonstrate throughout the accreditation term, the attributes of an accreditable organization, as reflected in the standards found in the *Accreditation Handbook for Ambulatory Health Care*. The dedication and effort necessary for an organization to be accredited is substantial and the compliance with those standards implies a commitment to continual self-evaluation and continuous improvement. Since your organization was required to submit a plan for improvement, receipt of this letter denotes acceptance of the plan for improvement. Your organization is required to undergo an interim survey so that AAAHC may monitor compliance with the Accreditation Standards.

In accordance with AAAHC requirements, your organization has submitted a Plan for Improvement that describes any follow-up or corrective action taken by your organization following the most recent on-site survey. As stated in the current *Accreditation Handbook*,

> An interim survey will be conducted when the AAAHC determines that an on-site visit is necessary to review the organization's implementation of the PFI. The organization will be notified of the time frame for the interim survey to occur after the accreditation survey. Following the interim survey, the organization's accreditation term may be maintained, reduced, or revoked.
>
> Organizations electing an Early Option Survey (EOS) are eligible to receive a three-year term of accreditation; however, the organization must undergo an interim survey to assess the organization's continued compliance with the accreditation Standards. The interim survey will not be limited to a review of the deficiencies noted in the previous survey report; all core and applicable adjunct Standards will be reviewed.

Your organization will be contacted by the Scheduling Coordinator, who will work with your organization to confirm the surveyor(s) and dates of survey. Continuance of the current term of accreditation is contingent upon successful and timely completion of this survey.

AAAHC will be paying particular attention to the following:

- Adherence to the corrective actions indicated in the Plan for Improvement
- Mechanisms to prevent the reoccurrence of the deficiencies cited in the most recent survey
- For organization surveyed under the Early Option Survey Program, AAAHC will conduct a full survey to assess the continued implementation of all policies and processes for continued maintenance with the accreditation Standards.

We hope the survey has been beneficial to your organization in identifying its strengths and opportunities to improve. AAAHC trusts that you will continue to find the accreditation experience meaningful, not only from the benefit of having carefully reviewed your own operation, but also from the recognition brought by your participation in this survey process.

5250 Old Orchard Road, SUITE 200
Skokie, Illinois 60077
TEL (847) 853 6060
FAX (847) 853 9028
www.aaahc.org
info@aaahc.org

PREMIER ORTHOPAEDICS
& SPORTS MEDICINE, PLC

Skyline Care Center

3443 Dickerson Pike
Suite 190
Nashville, TN 37207
Telephone (615) 860-1580
Fax (615) 860-1541

www.premier-ortho.com

Steven G. McLaughlin, M.D.
L. Brett Babat, M.D.
Steve G. Salyers, M.D.
Daniel J. Burval, M.D.

Paul A. Abbey, M.D.
Malcom E. Baxter, M.D.
Joseph D. Chenger, M.D.
Robert M. Dimick, M.D.
Brandon H. Downs, M.D.
James M. Fish, D.O.
Jason K. Haslam, M.D.
William J. Jekot, M.D.
Christopher P. Kauffman, M.D.
Melvin D. Law, Jr., M.D.
Jeffrey P. Lawrence, M.D.
Robert W. Lohse, M.D.
Robert W. Lowe III, M.D.
William C. Mayfield, III, M.D.
Daniel J. McHugh, M.D.
Gregg A. Motz, M.D.
Vincent K. Novak, M.D.
V. Douglas Pierce, Jr., M.D.
Michael L. Reid, M.D.
R. James Renfro, Jr., M.D.
Marc A. Tressler, D.O.
Joseph A. Wieck, M.D.

Lawrence Brett Babat, M.D. will admit patients for Jay Parekh, D.O.

L. Brett Babat, M.D.

Public Notices

0101676195
NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. §68-11-1601, et seq., and the Rules of the Health Services and Development Agency, that MHA of Middle Tennessee, LLC ("Applicant"), 28 White Bridge Road, # 210, Nashville, Davidson County, TN 37205, owned and managed by itself, intends to file an application for a Certificate of Need for the addition of interventional pain management services at its ASTC. The Applicant currently provides manipulation under anesthesia ("MUA") services. This new service will be provided in the same one procedure room which is currently licensed. There are no beds and no major medical equipment involved with this project. No other health services will be initiated or discontinued. It is proposed that Medicare, TennCare, commercially insured, and private-pay patients will be served by the ASTC, which will be licensed by the Tennessee Department of Health. The estimated project cost is anticipated to be approximately $700,000.00.

The anticipated date of filing the application is August 15, 2013.

The contact person for this project is E. Graham Baker, Jr., Attorney, who may be reached at 2021 Richard Jones Road, Suite 350, Nashville, Tennessee, 37215, 615/370-3380.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Frost Building
161 Rosa L. Parks Blvd., 3rd Floor
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Public Notices

0101673338
NOTICE OF PUBLIC AUCTION

A public auction will be held on Wednesday August 28, 2013, 12:00pm local time at Roundcherk, 750 Cowan Street, locker 107, Nashville, TN 37207. Contents of the "Light the World" leased space shall be sold to satisfy the owner's lien.

HomeFinder

Also search Tennessean Classifieds at www.tennessean.com, click on Classifieds.

Rentals

Apts - Furnished

AIRPORT AREA
581 Murfreesboro Pike. Furnished efficiency apt w/TV, $575 mo. $100 dep. All utils paid. Cable TV + HBO & pool access. Call 615-256-7155.

Apts - Furnished

Apts - Furnished

OLD HICKORY: 1 BR furn. w/all utilities paid including cable. Starting at $219 wk 847-4290

Apts - Unfurnished Davidson East

Sorry We Are Full
Pre-Lease for Sept. Biltmore Place Apts. A Place you will want to call HOME!
Call 615-361-6257

Apts - Unfurnished Davidson North

Apts - Unfurnished Davidson Southeast

Place your ad today! Call 242-SALE

Apts - Unfurnished Davidson South

Apts - Unfurnished Davidson Southeast

AIRPORT AREA
581 Murfreesboro Pike. Unfurnished Efficiency Apartment. $450 mo. + $100 deposit. All utilities paid. Call 615-256-7155

Awesome and Affordable
1 & 2 BR Apts
Call today!!!

WOW!
Unbelievably GREAT Prices!! SOUTH BROOK APTS
Don't wait... Call Today!

Apts - Unfurnished Davidson West

Condominiums/ Townhomes

MADISON
1 Bdrm Condo

Apts - Unfurnished Davidson South

FOXCROFT APTS
NOLENSVILLE RD/HARDING PLACE
1 Month Free - You Choose Month
345 Paragon Mills Rd.

Area Locator Map for Garage Sales & Real Estate

1. Murfreesboro Road to I-65
2. I-65 to Charlotte Pike
3. Charlotte Pike to Cumberland River West
4. Cumberland River West to Clarksville Pike
5. Clarksville Pike to Dickerson Pike
6. Dickerson Pike to Cumberland River East- Madison
7. Cumberland River East to I-40 Donelson-Lebanon Road
8. I-40 to Murfreesboro Rd.- Percy Priest Lake-Airport
9. Sumner County- Hendersonville, Gallatin, Old Hickory Boulevard
10. Williamson County-Franklin, Brentwood, Fairview
11. Wilson County-Lebanon, Mt. Juliet
12. Cheatham County
14. Robertson County
15. Dickson County
16. Maury County- Spring Hill, Columbia
18. Marshall County- Lewisburg, Chapel Hill
21. 22. Rutherford County- Murfreesboro, Smyrna, La Vergne
71. 77. Montgomery County- Clarksville, Ft. Campbell

bargains under $50

To place a FREE ad for an item under $50, call 242-SALE. The categories listed below also can be found, with additional items, elsewhere in the Classifieds.

stuff

Antiques

Building Materials

Collectibles

Lawn/Garden

Medical Equipment

Misc. Merchandise

AC/Heating

Health & Beauty

careerbuilder

garage sales

stuff

Garage Sales

Garage Sales - Cheatham

ESTATE SALE

MICHAEL TAYLOR
Estate/Moving Sales
EstateSales.net

ESTATE SALE

Multi-Family

ESTATE SALE

MOVING SALE

ESTATE SALE

MICHAEL TAYLOR
Estate/Moving Sales
EstateSales.net

Duplexes

ANTIOCH
2 BDRM, 2 1/2 BA, newly painted, all appliances, hookups, FP, central H/A, $775 mo. + dep. Call 615-242-5800

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1-5 BR Available - All Prices Sizes & Areas. Bad Cr, Say 8 OK, 100's avail NOW! 888-471-7368

Homes For Rent

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Commercial Property For Lease

Commercial Property For Sale

Commercial Property For Sale

FOR SALE OR LEASE

Lease/Purchase Option

Real Estate Residential

Condominiums/ Townhomes

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Mobile Homes/ Lots For Rent

Rooms/Efficiencies

Homes - Area 1

Homes - Area 10

Homes - Area 11

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Land/Farms - Davidson Co.

Land/Farms - Williamson Co.

Land/Farms - Other Counties

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MAURY CO

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REAL ESTATE WANTED

Resort/Recreation Property

Real Estate Auctions

Real Estate & Commercial

ALEXANDER Auctions & Real Estate Sales

Absolute Auction
BRICK HOME
11.31 SCENIC ACRES

2013 AUG 15 PM 2 33

State of Tennessee
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

October 1, 2013

E. Graham Baker, Jr., Esq.
Weeks and Anderson
2021 Richard Jones Road, Suite 350
Nashville, TN 37215

RE: Certificate of Need Application -- MUA of Middle Tennessee, LLC - CN1308-031

Dear Mr. Baker:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need for the addition of interventional pain management services at 28 White Bridge Road, #210, Nashville (Davidson County), TN 37205. The estimated project cost is $113,000.00.

Please be advised that your application is now considered to be complete by this office. Your application is being forwarded to the Tennessee Department of Health and/or its representative for review.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on October 1, 2013. The first sixty (60) days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the sixty (60) day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review within the thirty (30)-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on December 18, 2013.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill
Executive Director

MMH:mab

cc: Trent Sansing, CON Director, TDH

State of Tennessee
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

MEMORANDUM

TO: Trent Sansing, CON Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Cordell Hull Building, 6th Floor
425 Fifth Avenue North
Nashville, Tennessee 37247

FROM: Melanie M. Hill
Executive Director

DATE: October 1, 2013

RE: Certificate of Need Application
MUA of Middle Tennessee, LLC - CN1308-031

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on October 1, 2013 and end on December 1, 2013.

Should there be any questions regarding this application or the review cycle, please contact this office.

MMH:mab

Enclosure

cc: E. Graham Baker, Jr., Esq.

2013 AUG 8 PM 1 41

LETTER OF INTENT
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the *Tennessean* which is a newspaper of general
(Name of Newspaper)

circulation in Davidson County, Tennessee, on or before August 10, 2013 for one day.
(County) (Month / day) (Year)

==========

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601, et seq., and the Rules of the Health Services and Development Agency, that MUA of Middle Tennessee, LLC ("Applicant"), 28 White Bridge Road, # 210, Nashville, Davidson County, TN 37205, owned and managed by itself, intends to file an application for a Certificate of Need for the addition of interventional pain management services at its ASTC. The Applicant currently provides manipulation under anesthesia ("MUA") services. This new service will be provided in the same one procedure room which is currently licensed. There are no beds and no major medical equipment involved with this project. No other health services will be initiated or discontinued. It is proposed that Medicare, TennCare, commercially insured, and private-pay patients will be served by the ASTC, which will be licensed by the Tennessee Department of Health. The estimated project cost is anticipated to be approximately $200,000.00.

The anticipated date of filing the application is: August 15, 2013.

The contact person for this project is E. Graham Baker, Jr., Attorney
(Contact Name) (Title)

who may be reached at: his office located at 2021 Richard Jones Rd. Suite 350
(Company Name) (Address)

Nashville TN 37215 615 /370-3380
(City) (State) (Zip Code) (Area Code / Phone Number)

E. Graham Baker, Jr. August 08, 2013 graham@grahambaker.net
(Signature) (Date) (E-mail Address)

==========

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Frost Building
161 Rosa L. Parks Blvd., 3rd Floor
Nashville, Tennessee 37243

==========

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

==========

* The project description must address the following factors:

1. General project description, including services to be provided or affected.
2. Location of facility: street address, and city/town.
3. Total number of beds affected, licensure proposed for such beds, and intended uses.

State of Tennessee
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

August 23, 2013

E. Graham Baker, P.C.
Weeks and Anderson
2021 Richard Jones Road, Suite 350
Nashville, TN 37215

RE: Certificate of Need Application CN1308-031
MUA of Middle Tennessee, LLC

Dear Mr. Baker:

This will acknowledge our August 15, 2013 receipt of your application for a Certificate of Need for the addition of interventional pain management services at 28 White Bridge Road, #210, Nashville (Davidson County), TN 37205.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 4:00 p.m., Wednesday August 28, 2013. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

---

1. **Section A, Item 6**

   Are there any members of MUA of Middle Tennessee, LLC who are affiliated with Tennessee Spine and Nerve Institute, Inc.? Please discuss.

2. **Section A, Item 12**

   Please indicate if there have been any discussions by the applicant with any TennCare MCO's regarding contracting for this proposed project. If so, what is the stage of discussion?

3. **Section B, Project Description, Item I**

   Please explain why the applicant chose to file this application rather than request an Agency determination regarding whether MUJA fell under the umbrella of MUA.

   Please provide a brief description of the service area, need and funding for the proposed project.

The applicant states they are forced by insurers to attempt less intensive pain relief methods prior to attempting traditional MUA. Please provide any documentation in the form of correspondence, policies and procedures, provider manuals, clinical criteria, etc. from insurance companies that support this statement.

Since the applicant will only be performing interventional pain management services, has the applicant requested and received any waivers from the Tennessee Department of Health, Board of Healthcare Licensing Facilities regarding operating rooms?

There appears to be an existing state registered licensed pain management clinic at the applicant's address. Please clarify the applicant's relation to that clinic and if the proposed project will be registered separately with the State of Tennessee as a registered pain clinic.

Will all patients having a pain management injection also receive a MUA procedure or are there occasions where a patient will have a pain management procedure and no MUA procedure or occasions where a patient will have no pain management procedure but receive a MUA procedure? If these several scenarios are possible please breakout the expected percentage of patients that will fall into each category.

On page 9 of the application the applicant lists the Medicare and TennCare revenue projections. However, what is listed is the percentage of patients not the percentage of revenue. Please clarify.

Are interventional pain management procedures being performed now by the applicant or affiliated entity in an office setting at 28 White Bride Road, Nashville (Davidson County), TN 37909?

4. **Section B, Project Description, Item II A**

Please clarify if the applicant is describing the development of the proposal since the project appears to not have any renovation or construction cost.

5. **Section C, Need Item 1**

Please discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan."

6. **Section C, Need, Item 1.a., Service Specific Criteria-ASTC (Item 1) and Section C. Need, Item 6**

The applicant projects 3,455 and 4,442 interventional pain management procedures in Year One and Year Two.

Is it possible for a patient to have more than one pain management procedure per visit? If yes, please provide the projected utilization based on patient visits/cases, since ASTC utilization standards are now based on cases.

Please explain how procedures based on historical utilization were determined. Is it based on the MUJA procedures performed prior to the HSDA ruling? Please provide the details of the methodology used.

Please explain what you mean by anecdotal information from physicians. Please give some specific examples.

Of these procedures how many are based on historical utilization and how many from anecdotal information from doctors in the Nashville area.

In addition, please clarify if the mentioned Nashville doctors have verbally committed or have provided letters stating they will refer to the proposed project.

7. **Section C, Need, Item 1.a,Service Specific Criteria-ASTC (4) Need and Economic Efficiencies**

   Please address the following statement as related to this proposal:

   "A CON application to establish an ASTC or to expand existing services of an ASTC should not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed, if those services are known and relevant, within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above."

8. **Section C, Need, Item 1.a,Service Specific Criteria-ASTC (6) Other Standards and Criteria**

   Please provide documentation that a majority of patients reside within 60 minutes average drive time to the applicant's facility.

9. **Section C, Need, Item 1.a,Service Specific Criteria-ASTC (9) Other Standards and Criteria**

   Please clearly state the specific methodology and assumptions by which the utilization for the first 8 quarters was projected.

10. **Section C, Need, Item 1.a,Service Specific Criteria-ASTC (10) Other Standards and Criteria**

    Please list the physicians that will provide pain intervention services in the proposed ASTC and their qualifications/certification/specialties.

    Please identify the Medical Director and his/her qualifications.

    Please address question 10 (b).

    Please identify the four physicians that have used the existing ASTC.

    Please document that the applicant has a contract for anesthesiology services.

    Please identify the TennCare MCOs with which the anesthesiology service contracts.

11. **Section C, Need, Item 1.a,Service Specific Criteria-ASTC (11) Other Standards and Criteria, Access to ASTCs**

Please indicate if there are any designated medically underserved areas in the proposed service area as designated by the United States Health Resources and Services Administration.

The applicant has listed insurance plans that have contracted with the applicant. Please indicate if the listed insurance companies will contract with the applicant for interventional pain management services.

12. **Section C, Need, Item 3.**

Please provide the projected number and percentage of patients by county of residence.

13. **Section C, Need, Item 4.A.**

Your response to this item is noted. Using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, please complete the following table and include data for each county in your proposed service area.

Variable	*Davidson*	*Robertson*	*Rutherford*	*Williamson*	*Service Area*	*TN*
Current Year (CY), Age 65+						
Projected Year (PY), Age 65+						
Age 65+, % Change						
Age 65+, % Total (PY)						
CY, Total Population						
PY, Total Population						
Total Pop. % Change						
TennCare Enrollees						
TennCare Enrollees as a % of Total Population						
Median Age						
Median Household Income						
Population % Below Poverty Level						

14. Section C, Need Item 5

Please indicate if there are unimplemented CONs of similar institutions in the service area.

The chart in Attachment C.N.5.C is noted. For comparative purposes, please compare the anticipated charges by the applicant to the 4 listed ASTC's.

The last three years of JAR data in attachments C.N.5.B. and C.N.5.C includes 2012 provisional data. Please also include final 2009 Joint Annual Report data in those charts.

15. Section C, Economic Feasibility, Project Costs Chart

What type of moveable equipment does the applicant intend to purchase?

Please indicate if the applicant already has fluoroscopic equipment for injections. If not, does the applicant intend to purchase fluoroscopic equipment?

16. Economic Feasibility, Item 2, Project Funding

Please provide documentation from the Chief Financial Officer of adequate cash reserves to pay for project costs.

17. Economic Feasibility, Item 4, Historical Data Chart and Projected Data Chart

Please clarify the period of time interventional pain management services were provided by the applicant as mentioned in this section.

A Medical Director is listed as an expense of $337,500 per year in the interventional pain management proposed project and in the total facility Projected Data Chart. Since the amount is the same on both, does this mean the physician will devote all his time to interventional pain management?

Please clarify if $125,000 in salaries and wages will cover all full time employees associated with this project.

Why is rent in Year 1 in the amount of $40,380 for the proposed interventional pain management project higher than rent in the amount of $39,633 in Year 1 for the whole facility on the Projected Data Charts?

Why is depreciation and rent the same amount on the Projected Data Chart for Interventional Pain Management and the Projected Data Chart for the whole facility?

There appears to be calculation errors in the amount of operating expenses in Year One and Year Two on the Projected Data Chart for the total facility. Please correct and resubmit a replacement page.

Is it reasonable to expect to be able to hire an ASTC administrator for $12-15K?

18. Section C., Economic Feasibility, Item 10

The applicant balance sheet reflects a current ratio of .86:1 and $13,735 in cash. Please verify the applicant has adequate cash to meet short term obligations.

19. Section C, Economic Feasibility, Item 6.B

Please indicate the top 10 projected CPT reimbursed procedures for this proposed project.

CPT Code	Brief Description

20. Section C, Orderly Development, Item 2

Please identify the 4 ASTCs the applicant mentions in this section that appear to limit their services to interventional pain management services.

21. Section C, Orderly Development, Item 3

Please provide the anticipated staffing pattern for the proposed project. Also, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor and Workforce Development and/or other documented sources.

22. Section C, Orderly Development, Item 7

The applicant will seek accreditation through AAAHC. Please clarify if this certification applies to Intervention Pain Management Procedures.

23. Project Completion Forecast Chart

The agency decision date appears to be incorrect. Please revise and resubmit the Project Completion Forecast Chart.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is October 22, 2013. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the

application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ə 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

Phillip M. Earhart/MF

Phillip M. Earhart
Health Services Development Examiner

Enclosure/PME

COPY-

SUPPLEMENTAL-1

MUA of Middle Tennessee, LLC

CN1308-031

WEEKS & ANDERSON
An Association of Attorneys

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DIRECT TELEPHONE NUMBER: 615/370-3380

September 30, 2013

Phillip M. Earhart
Health Services Development Examiner
Tennessee Health Services & Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243

RE: Supplemental Information: Certificate of Need Application CN1308-031
MUA of Middle Tennessee, LLC

Dear Phillip:

Enclosed are three (3) copies of responses to your supplemental questions regarding the referenced Certificate of Need application. If you have any additional questions, please contact me.

Sincerely,

E. Graham Baker, Jr.
/np

Enclosures as noted

SUPPLEMENTAL- # 1
September 30, 2013
11:23am

SEP 30'13 11:18

AFFIDAVIT

STATE OF TENNESSEE
COUNTY OF DAVIDSON

NAME OF FACILITY: MUA of Middle Tennessee, LLC (CN1308-031)

I, E. Graham Baker, Jr., after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge, information and belief.

E. Graham Baker, Jr. Attorney at Law
Signature/Title

Sworn to and subscribed before me, a Notary Public, this 30th day of September, 2013; witness my hand at office in the County of Davidson, State of Tennessee.

Nadean E. Poteet
NOTARY PUBLIC
My Commission expires July 3, 2017

NADEAN E. POTEET
STATE OF TENNESSEE
NOTARY PUBLIC
DAVIDSON COUNTY

1. Section A, Item 6

Are there any members of MUA of Middle Tennessee, LLC who are affiliated with Tennessee Spine and Nerve Institute, Inc.? Please discuss.

Drs. Terry Totty and Lance Benedict, who own 50% of MUA of Middle Tennessee, also own Tennessee Spine and Nerve Institute. Drs. Odell andYim and Mr. Goorevich all have ownership interests in MUA of Middle Tennessee, but have no ownership interest in, or any affiliation with, Tennessee Spine and Nerve Institute.

2. Section A, Item 12

Please indicate if there have been any discussions by the applicant with any TennCare MCO's regarding contracting for this proposed project. If so, what is the stage of discussion?

We have a contract with Amerigroup to provide services for interventional pain procedures in the MUA of Middle Tennessee Surgery center. We are currently negotiating with Americhoice to get a contract for these services as well.

3. Section B, Project Description, Item I

Please explain why the applicant chose to file this application rather than request an Agency determination regarding whether MUJA fell under the umbrella of MUA.

We were advised by the HSDA that needed to file a new CON in order to perform any type of injections in the surgery center.

Please provide a brief description of the service area, need and funding for the proposed project.

As stated, our service area is the same as our original MUA application, and consists of Davidson, Williamson, Rutherford, and Robertson Counties, which counties reflect patient origin (in number order) for 98% of the patients of Tennessee Spine and Nerve Institute, Inc. See *Attachment C.N.3* for a map of the proposed service area.

It is important to note that the service area for this project is based, in large part, on the actual patient origin information for two of the member/owners of the Applicant. Drs. Benedict and Totty currently serve patients from about 7 Middle Tennessee Counties, and the four top counties, in order of number of patients, are: Davidson, Williamson, Rutherford and Robertson Counties.

Physicians have expressed concern about the treatment of chronic pain. Chronic pain has both chemical and mechanical components. Such treatment is difficult, sometimes ineffective, and has risks. These risks include narcotic abuse, misuse and diversion, and infection (such as Epidural Steroid Injections). There appears to be general consensus that a procedure that could significantly lower pain scores, improve functional capacity, and reduce narcotic use would be invaluable in the treatment of chronic pain. Manipulation under Anesthesia ("MUA") is such a procedure, and the Applicant is already approved for this service.

MUA is a modality which has been used by practitioners (doctors of chiropractic, doctors of osteopathic medicine, and medical doctors) since the early 1930s. The process involves relaxing the patient (with anesthesia), and making corrections to biomechanical abnormalities by stretching and manipulation. Following the procedure, the patient gains a range of motion and/or relief of pain.

The Applicant is forced by insurers to attempt less intensive pain relief methods prior to attempting traditional MUA. These measures include interventional pain management services such as joint injections. The HSDA originally determined that such procedures were included under MUA, and the Applicant provided such procedures for some time. Later, the HSDA determined that the Applicant is not approved for such interventional pain management services. Since the Applicant cannot conduct the MUA procedures for which it has already been approved without attempting interventional pain management procedures first, this application is being filed.

This Application includes administrative costs, and a relatively small amount for equipment, only (already purchased), and there is no construction or renovation. The higher of FMV and/or lease costs for the site were approved when the original ASTC was approved. Cash reserves have been utilized to pay for these nominal costs.

The applicant states they are forced by insurers to attempt less intensive pain relief methods prior to attempting traditional MUA. Please provide any documentation in the form of correspondence, policies and procedures, provider manuals, clinical criteria, etc. from insurance companies that support this statement.

Please see attachments *UHC-MUA Policy* and *BCBST-MUA*.

Since the applicant will only be performing interventional pain management services, has the applicant requested and received any waivers from the Tennessee Department of Health, Board of Healthcare Licensing Facilities regarding operating rooms?

Our facility procedure room was built to operating room codes for MAC sedation as a result of our original MUA application. When our existing ASTC was approved, we obtained minimal waivers, such as no requirement for an electrical generator, since we were not performing traditional surgery, but were performing manual procedures. We do not anticipate further waivers as a result of this application.

There appears to be an existing state registered licensed pain management clinic at the applicant's address. Please clarify the applicant's relation to that clinic and if the proposed project will be registered separately with the State of Tennessee as a registered pain clinic.

The address for MUA of Middle Tennessee, LLC (our ASTC) is Suite 210. Tennessee Spine and Nerve Institute, a licensed pain management facility, is Suite 208. The ASTC will be performing services for the patients of Tennessee Spine and Nerve. This CON application is for interventional pain procedures. MUA of Middle Tennessee, LLC will not be a registered pain clinic, as there will be no narcotics scripted out of the surgery center.

Will all patients having a pain management injection also receive a MUA procedure or are there occasions where a patient will have a pain management procedure and no MUA procedure or occasions where a patient will have no pain management procedure but receive a MUA procedure? If these several scenarios are possible please breakout the expected percentage of patients that will fall into each category.

MUA procedures and interventional pain management procedures will not be performed at the same time on the same patient. If interventional pain management is not successful, a patient may undergo traditional MUA treatment later. As we are required (by insurers) to attempt interventional pain management procedures first, we do not anticipate attempting such procedures on patients who have had the more traditional MUA procedure. However, it is important to note that we will attempt to alleviate pain in all of our patients with whatever means for which we are approved, based on their respective needs at any given time.

On page 9 of the application the applicant lists the Medicare and TennCare revenue projections. However, what is listed is the percentage of patients not the percentage of revenue. Please clarify.

We listed the percentage of patients, as this is the estimated percentage that will be referred for procedures in the surgery center. The percentage of revenue from Medicare is less than

commercial, and the percentage of revenue from Medicaid is less than both. As a practical matter, it is almost impossible to predict the exact amount of revenue from each payor source. Instead, it is our understanding that applicants normally multiply the gross revenue, deductions, and net revenue projections by the respective percentages of patients. Hence, Medicare revenue would likely approach $1,858,790 (Gross revenue of $4,646,975 x 40% = $1,858,790).

Likewise, it is anticipated that the impact on Medicaid will be $139,410 (Gross revenue of $4,646,975 x 10% x 30% State Share = $139,410).

Are interventional pain management procedures being performed now by the applicant or affiliated entity in an office setting at 28 White Bride Road, Nashville (Davidson County), TN 37909?

It is important to note that many pain management procedures can be performed in a physician's office. Currently, our pain boarded anesthesiologist is doing most spine injection procedures in the surgery center. He uses sedation for a lot of procedures and prefers the safer environment. He does do some pain management injections in the office of Tennessee Spine and Nerve.

4. Section B, Project Description, Item II A

Please clarify if the applicant is describing the development of the proposal since the project appears to not have any renovation or construction cost.

As stated, all costs for this project are administrative costs, only. This application is for a new service at an existing ASTC. There is no renovation or construction cost associated with this application.

5. Section C, Need Item 1

Please discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan."

The State Health Plan's Five Principles for Achieving Better Health were written to initiate a dialogue as to how the State of Tennessee can improve its state health ranking.

We will address each principle and how MUA of Middle Tennessee relates to it by expanding the services to include interventional pain procedures.

Under **Principle Number One, Healthy Lives**, the top three health conditions in the State of Tennessee in order were:
1) 79% Obesity and Overweight,
2) 71% Heart attack, stroke, high blood pressure, and cardiovascular disease and
3) 63% Diabetes.

In addition, alcoholism and drug abuse were also found to be of importance. When a patient has chronic pain, without any education or relief of pain, the odds of improving his/her health are low. Treating their pain in the most efficacious and safe manner while educating them on a healthier lifestyle with the condition they have will improve their overall health. One of the primary objectives in increasing the services of MUA of Middle Tennessee is to improve the safety of patients who are in need of pain procedures. Many, if not most, patients who have chronic pain and are in need of interventional pain procedures have numerous co-morbidities, as noted above.

The adherence to the strict guidelines by CMS and our accreditation organization, AAAHC, which establishes the policies and procedures required for the appropriate surgery center environment, is our basis for patient care. In addition, the surgery center staff and physicians who have followed the patient from their initial visit have intimate knowledge of all of the patient's health problems, which will lessen the odds of an adverse event occurring during a procedure. Finally, it is and always has been our goal to decrease the amount of drug abuse, both prescription and illegal, in our patient population. No medications will be scripted in the surgery center setting.

Principle Number Two ,Access to Care, has been increased by MUA of Middle Tennessee by having a contract with Amerigroup. We are also working diligently on getting a contract with Americhoice, the other Medicaid providers in Middle Tennessee. We are credentialed with Medicare and most major commercial insurers. Also, as you may be aware, it is this patient population which has a higher incidence of prescription drug abuse, as well as co-morbidities. Being able to see these patients in a surgery center setting, provides a higher level of safety and decreases narcotic abuse.

One of the top ideas for improving **Principle Number Three, Economic Efficiency**, was to emphasize prevention in health care services. All patients who would receive procedures at MUA of Middle Tennessee would be required to have a one-on-one meeting with the physical medicine department of Tennessee Spine and Nerve Institute. A doctor of chiropractic medicine reviews diagnostics with each patient and goes over their particular health problems, and then structures a physical medicine approach for the individual patient. This could include nutritional counseling, physical therapy, chiropractic care, and manipulation under anesthesia, to basic exercise appropriate to the patient. This multi-discipline approach has been done throughout the

country with great efficacy and results. Our goal is to have all patients accept accountability for their individual health. We believe we will have higher quality outcomes of the procedures performed in the surgery center if we are able to establish this accountable thought process in the patient, through education.

Due to the higher standards surgery centers are held to, **Principle Four, Quality of Care**, is easily established. MUA of Middle Tennessee meets the definition of "high quality care" under this principle. Having a licensed and boarded pain medical doctor with a staff that is familiar with the patients and is specifically trained, and follow the required strict policies and procedures, creates the atmosphere for an effective, patient-centered, timely, efficient and equitable surgery center.

In addition "Patient Centered Care" is one of the big reasons we decided to have a surgery center in the first place. All of our healthcare providers, from the MD's, the physician extenders, chiropractors, therapists, and all support staff, partner with each other and the patient to establish the best possible care with the primary goal being great outcomes. We believe that having access to our own surgery center with providers who are familiar with the "whole patient" performing the procedures, is an improvement in the quality of care.

We believe increasing the services of MUA of Middle Tennessee to include interventional pain procedures relates to **Principle Five, Health Care Workforce** by having the existence of a comprehensive approach to pain treatment not based on medications. A pain-boarded physician performing procedures in the surgery center is the leader of the multi-disciplinary team who will examine, educate and treat the patient under the strict policies and procedures approved by the Governing Body of MUA of Middle Tennessee.

SUPPLEMENTAL- # 1
September 30, 2013
11:23am

6. Section C, Need, Item 1.a., Service Specific Criteria-ASTC (Item 1) and Section C. Need, Item 6

The applicant projects 3,455 and 4,442 interventional pain management procedures in Year One and Year Two.

Is it possible for a patient to have more than one pain management procedure per visit? If yes, please provide the projected utilization based on patient visits/cases, since ASTC utilization standards are now based on cases.

Our pain anesthesiologist will not perform more than one pain management procedure per visit.

Please explain how procedures based on historical utilization were determined. Is it based on the MUJA procedures performed prior to the HSDA ruling? Please provide the details of the methodology used.

Procedures were not entirely based on MUJA procedures performed prior to the HSDA ruling. The surgery center was not seeing patients until September of 2012 as we were not entirely credentialed until the end of August 2012. At that point, we started very slowly doing MUJA one day per week and MUA for the full three days if a patient qualified. Our pain anesthesiologist determined he could see between 18-20 patients per day depending upon the procedures he was doing. If the patient received manipulation this amount would decrease. By December of 2012, he was doing up to 15 procedures per day twice per week. We ceased doing anything in the center as of Jan. 2013. We had to start again slowly in May of 2013, all over again. Based on what little historical data we had and with the amount of new patients we see, we estimated the numbers contained in the application.

Please explain what you mean by anecdotal information from physicians. Please give some specific examples.

We used the term “anecdotal information” to refer to information received by word of mouth, as opposed to some national or local study. The projections we made in the application were based on what our physicians, including our anesthesiologist, told us about the patients they were seeing. An example is given immediately above (the prior question/answer).

Of these procedures how many are based on historical utilization and how many from anecdotal information from doctors in the Nashville area.

Historically, we know we are able to do twenty procedures per day at maximum and we were averaging approximately 15 per day with the history we had.

In addition, please clarify if the mentioned Nashville doctors have verbally committed or have provided letters stating they will refer to the proposed project.

The doctors who currently refer to us do so for pain management services, which would include any treatment decided by a pain management facility. All referring physicians receive a letter describing what type of treatment their patient is getting.

7. Section C, Need, Item 1.a,Service Specific Criteria-ASTC (4) Need and Economic Efficiencies

Please address the following statement as related to this proposal:

"A CON application to establish an ASTC or to expand existing services of an ASTC should not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed, if those services are known and relevant, within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above."

According to the latest JAR information (2012, Provisional), the four ASTCs which limit their procedures to pain management averaged 2,359 procedures per room (see Attachment C.N.5.B). This amount (2,359) is over 26% higher than the stated Guideline amount of 1,867 cases per room. The current utilization amount is, therefore, 126% utilization – well above the 70% utilization suggested by this Guideline.

8. Section C, Need, Item 1.a,Service Specific Criteria-ASTC (6) Other Standards and Criteria

Please provide documentation that a majority of patients reside within 60 minutes average drive time to the applicant's facility.

According to the official TN Department of Transportation State Map, it is 18 miles from Nashville to Franklin, 28 miles from Nashville to Murfreesboro, and 28 miles from Nashville to Springfield (the county seats were used for each of the four counties in our service area, since such cities are centrally located in each county). According to MAPQUEST, it takes about 28 minutes to drive from Nashville to Franklin, about 38 minutes to drive from Nashville to Murfreesboro, and about 37 minutes to drive from Nashville to Springfield. Therefore, the majority of patients in these four counties should be able to arrive at the Applicant's site within 60 minutes drive time.

9. Section C, Need, Item 1.a,Service Specific Criteria-ASTC (9) Other Standards and Criteria

Please clearly state the specific methodology and assumptions by which the utilization for the first 8 quarters was projected.

Tennessee Spine and Nerve Institute currently sees between 150 and 200 new patients per month. According to our pain anesthesiologist approximately 80 percent of those patients are a candidate for interventional procedures for pain. He estimates two procedures/cases per patient in a given year. Using 150 patients as our base, that equates to 1,800 patients times 80% or 1440 receiving procedures x 2 cases, or 2880 total cases per year. If we saw 200 new patients per month then the math would be 2,400 new patients times 80 percent which equals 1,920 patients times two cases equals 3,840 cases per year. We anticipate increasing our new patient referrals as we are able to do more services. At 4,442 cases, we are approaching the maximum one pain physician can do in our center and will have to hire another physician.

As for our quarterly assumptions, we simply divided the projected number of annual procedures by 4 and reported that number. Any manner of projecting how many procedures, by quarter for 8 successive quarters, would be speculative. As we have some history of providing the service, we made the logical assumption that there would not be so much of a "ramping-up" time frame for this service.

10. Section C, Need, Item 1.a,Service Specific Criteria-ASTC (10) Other Standards and Criteria

Please list the physicians that will provide pain intervention services in the proposed ASTC and their qualifications/certification/specialties.

Jay Parekh, DO. Anesthesiologist, Boarded in Pain Medicine

Please identify the Medical Director and his/her qualifications.

Co-Medical Directors-Jay Parekh, DO, Anesthesiologist, Boarded in Pain Medicine. Melvin Butler, MD, Boarded in Internal Medicine, and Gastroenterology

Please address question 10 (b).

We anticipate the existing physicians, listed above and below, will continue to utilize the ASTC. As stated, our ASTC is licensed and accredited by AAAHC. As such, we have sufficient staff to add this type of service, and no additional staff will be needed.

Please identify the four physicians that have used the existing ASTC.

There were really five physicians, as follows:

James Ladson, MD-Anesthesiologist, Fellowship in Pain Medicine.
Jay Parekh, DO-Anesthesiologist, Boarded in Pain Medicine.
Michael Skaredoff, MD-Anesthesiologist, Boarded in Pain Medicine.
Lance Benedict, DC-Chiropractor.
Terry Totty, DC-Chiropractor.

Please document that the applicant has a contract for anesthesiology services.

MUA of Middle Tennessee has an anesthesiology agreement with Sweet Dreams Anesthesia, Inc.

Please identify the TennCare MCOs with which the anesthesiology service contracts.

The anesthesiology service we contract with (Sweet Dreams) has contracts with Americhoice, Amerigroup and BlueCare. They also have contracts with all insurers.

11. Section C, Need, Item 1.a,Service Specific Criteria-ASTC (11) Other Standards and Criteria, Access to ASTCs

Please indicate if there are any designated medically underserved areas in the proposed service area as designated by the United States Health Resources and Services Administration.

Yes. Please see *Supplemental Medically Underserved Areas.*

The applicant has listed insurance plans that have contracted with the applicant. Please indicate if the listed insurance companies will contract with the applicant for interventional pain management services.

Yes, the listed insurance companies will contract with MUA of Middle Tennessee for interventional pain management procedures.

12. Section C, Need, Item 3.

Please provide the projected number and percentage of patients by county of residence.

The following Year 1 approximations are based on historic patient origin for the Applicant owners:

County	# Pts	% Pts
Davidson County	1,040	30.1%
Robertson County	686	19.8%
Rutherford County	697	20.2%
Williamson County	1,032	29.9%

It is important for the reviewer to understand that we projected seeing 3,455 patients in Year 1. This projection was based on fact that about 98% of our existing patients originated from the 4 county service area. However, the above numbers represent 100% of the projected 3,455 patients, and the 3,455 patients represents about 98% of the applicant's current case load.

13. Section C, Need, Item 4.A.

Your response to this item is noted. Using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, please complete the following table and include data for each county in your proposed service area.

Variable	Davidson	Robertson	Rutherford	Williamson	Service Area	TN
2013 Age 65+	72,486	8,329	24,822	18,589	124,226	904,587
2015 Age 65+	76,318	8,991	27,598	20,689	133,596	960,158
Age 65+, % Change	5.3%	7.9%	11.2%	11.3%	7.5%	6.1%
2015 Age 65+, % Total	12.4%	12.5%	10.2%	10.5%	11.6%	14.7%
2013 Total Pop.	605,923	69,680	261,331	188,259	1,125,193	6,414,297
2015 Total Pop.	614,222	72,006	271,112	196,824	1,154,164	6,530,459
Total Pop. % Change	1.4%	3.3%	3.7%	4.5%	2.6%	1.8%
TennCare Enrollees 2012	119,510	11,452	36,715	8,690	176,367	1,206,538
TennCare Enrollees as a % of Total Pop.	19.7%	16.4%	14.0%	4.6%	15.7%	18.8%
Median Age	33.9	37.6	32.2	38.5	N/A	41.3
Median Household Income 2007-2011	$46,737	$50,759	$54,433	$89,063	$240,992	$43,989
Below Poverty Level % 2007-2011	17.7%	13.2%	12.7%	5.5%	N/A	16.9%

14. Section C, Need Item 5

Please indicate if there are unimplemented CONs of similar institutions in the service area.

There are none, to our knowledge.

The chart in Attachment C.N.5.C is noted. For comparative purposes, please compare the anticipated charges by the applicant to the 4 listed ASTC's.

The last three years of JAR data in attachments C.N.5.B. and C.N.5.C includes 2012 provisional data. Please also include final 2009 Joint Annual Report data in those charts.

Please see *Supplemental C.N.5.B*, which shows requested 2009 utilization data for all ASTCs in the service area, *and Supplemental C.N.5.C*, which has the additionally-requested 2009 financial data.

The 2012 Gross and Net Charges per procedure of existing ASTCs were $1,261 and $440, respectively. Comparable figures for Year 1 for the Applicant are $1,345 and $269, respectively.

15. Section C, Economic Feasibility, Project Costs Chart

What type of moveable equipment does the applicant intend to purchase?

None. We already have an existing used C-Arm, which cost us approximately $60,000, and we utilized that equipment when we were providing the service under our prior approval by the HSDA. We included that historical cost in this application so as not to imply there were no historic costs associated with this service. In fact, there are no more costs associated with this project, and no more equipment will be purchased.

Please indicate if the applicant already has fluoroscopic equipment for injections. If not, does the applicant intend to purchase fluoroscopic equipment?

We do have a fluoroscope.

16. Economic Feasibility, Item 2, Project Funding

Please provide documentation from the Chief Financial Officer of adequate cash reserves to pay for project costs.

As stated, our ASTC is already licensed, and no renovation is necessary to add this service. In addition, all equipment needed is already purchased and in place (as we had been performing these procedures with prior HSDA approval). All costs associated with this project are administrative, only, and have already been paid. No more cash is needed to pay for this project.

17. Economic Feasibility, Item 4, Historical Data Chart and Projected Data Chart

Please clarify the period of time interventional pain management services were provided by the applicant as mentioned in this section.

Our pain anesthesiologist performed interventional joint injections from Sept. of 2012 through Dec. of 2012, again starting in May of 2013 through the present.

A Medical Director is listed as an expense of $337,500 per year in the interventional pain management proposed project and in the total facility Projected Data Chart. Since the amount is the same on both, does this mean the physician will devote all his time to interventional pain management?

This was an estimate on the cost of having co-medical directors, one of whom would perform the interventional procedures.

Please clarify if $125,000 in salaries and wages will cover all full time employees associated with this project.

Yes, it will, not counting the pain physician.

Why is rent in Year 1 in the amount of $40,380 for the proposed interventional pain management project higher than rent in the amount of $39,633 in Year 1 for the whole facility on the Projected Data Charts?

There are CAM charges that vary from year to year. We included them in the rent for year 1 in the interventional pain management project. After this year, we have a more accurate accounting of what the fees will be.

Why is depreciation and rent the same amount on the Projected Data Chart for Interventional Pain Management and the Projected Data Chart for the whole facility?

Our ASTC is already licensed. We are only adding a service with this application. Rent and Depreciation will remain the same, whether or not this application is approved.

There appears to be calculation errors in the amount of operating expenses in Year One and Year Two on the Projected Data Chart for the total facility. Please correct and resubmit a replacement page.

Please see replacement page 29-R.

Is it reasonable to expect to be able to hire an ASTC administrator for $12-15K?

The administrator will be shared with Tennessee Spine and Nerve institute, and this amount is the "share" to administrate the ASTC.

18. Section C., Economic Feasibility, Item 10

The applicant balance sheet reflects a current ratio of .86:1 and $13,735 in cash. Please verify the applicant has adequate cash to meet short term obligations.

The current facility is meeting all of its financial obligations, and will be no additional financial increases by obtaining a CON for interventional pain management procedures.

19. Section C, Economic Feasibility, Item 6.B

Please indicate the top 10 projected CPT reimbursed procedures for this proposed project.

CPT Code	Brief Description
63650	Dorsal column nerve stimulator
64555	Peripheral Nerve Neurostimulator
64635	Radiofrequency ablation-destruction of nerve by neurolysis lumbar one level
64633	Radiofrequency ablation-destruction of nerve by neurolysis-cervical one level
62311	Epidural steroid injection lumbar
62310	Epidural steroid injection cervical or thoracic
64493	Facet Injection Lumbar one level
64490	Facet injection cervical one level
64494	Facet injection lumbar second level
64491	Facet injection cervical second level.

20. Section C, Orderly Development, Item 2

Please identify the 4 ASTCs the applicant mentions in this section that appear to limit their services to interventional pain management services.

These are the four ASTCs listed in the original application (Attachment C.N.5.C) which list 100% interventional pain management services. They are: Premier Radiology Pain Management, St. Thomas Outpatient Neurosurgical, Tennessee Pain Surgery, and Crossroads Surgery.

21. Section C, Orderly Development, Item 3

Please provide the anticipated staffing pattern for the proposed project. Also, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor and Workforce Development and/or other documented sources.

We will use the following support staff: RN, MA/Receptionist, RT (Radiology Tech). We pay our RN $34/hr and the prevailing wage pattern is approximately $31/hr. We pay our MA $13/hour and the prevailing wage pattern is approximately $13.80. We pay our RT $24/hr and the prevailing wage pattern is approximately $23.50. No additional staff is required for the addition of this service. As for FTEs, we will utilize our existing 1 RN FTE, 1 MA/Receptionist FTE, and 1 RT FTE, and all of these existing staff will continue to be "shared" with other functions approved for our ASTC.

22. Section C, Orderly Development, Item 7

The applicant will seek accreditation through AAAHC. Please clarify if this certification applies to Intervention Pain Management Procedures.

We have already received certification from AAAHC for Interventional Pain Management Services. During their extensive two-day process, they observed our pain anesthesiologist performing interventional procedures and participating in manipulation under anesthesia.

23. Project Completion Forecast Chart

The agency decision date appears to be incorrect. Please revise and resubmit the Project Completion Forecast Chart.

Please see replacement page 41-R.

UnitedHealthcare

MEDICAL POLICY

MANIPULATION UNDER ANESTHESIA

Policy Number: 2012T0515F
Effective Date: May 1, 2012

Table of Contents

	Page
COVERAGE RATIONALE	1
BACKGROUND	2
CLINICAL EVIDENCE	3
U.S. FOOD AND DRUG ADMINISTRATION	9
CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)	9
APPLICABLE CODES	9
REFERENCES	16
POLICY HISTORY/REVISION INFORMATION	18

Related Medical Policies:
None

Related Coverage Determination Guidelines:
None

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COVERAGE RATIONALE

Manipulation under anesthesia (MUA) is proven for:

- Elbow joint for arthrofibrosis following elbow surgery or fracture
- Knee joint for arthrofibrosis following total knee arthroplasty, knee surgery, or fracture
- Pelvis for acute traumatic fracture or dislocation
- Shoulder joint for adhesive capsulitis (e.g. frozen shoulder)

Manipulation under anesthesia is unproven for:

- Ankle
- Finger*
- Hip joint or adhesive capsulitis of the hip
- Knee joint for any condition other than for arthrofibrosis following total knee arthroplasty, knee surgery, or fracture
- Pelvis for diastasis or subluxation

- Shoulder for any condition other than adhesive capsulitis (frozen shoulder)
- Spine
- Temporomandibular joint (TMJ)
- Toe
- Wrist

Published studies which are available are of relatively small sample size, short-term outcomes and lack of randomization or a control group.

* This policy does not apply to manipulation of the finger on the day following the injection of collagenase clostridium histolyticum (Xiaflex®) to treat Dupuytren's contracture.

Manipulation under anesthesia is unproven for serial manipulations for any body part or multiple body joints for the management of acute or chronic pain conditions. There is a lack of peer-reviewed published evidence supporting the need for multiple, repeat sessions of MUA for multiple body joints.

BACKGROUND

Manipulation under anesthesia (MUA) is a non-invasive procedure which combines manual manipulation of a joint or the spine with an anesthetic. In patients who are unable to tolerate manual procedures due to pain, spasm, muscle contractures, or guarding may benefit from the use of an anesthetic agent prior to manipulation. Anesthetics may include intravenous general anesthesia or mild sedation, injection of an anesthetic to the affected area, oral medication such as muscle relaxants, inhaled anesthetics, or any other type of anesthetic medication therapy. Because the patient's protective reflex mechanism is, absent under anesthesia, manipulation using a combination of specific short lever manipulations, passive stretches, and specific articular and postural kinesthetic maneuvers in order to break up fibrous adhesions and scar tissue around the joint, spine and surrounding tissue is made less difficult. Manipulation procedures can be performed under either: general anesthesia, mild sedation, or local injection of an anesthetic agent to the affected area (Reid, 2002).

Manipulation under anesthesia (MUA) may be accompanied by fluoroscopically-guided intra-articular injections with corticosteroid agents to reduce inflammation or manipulation under joint anesthesia/analgesia (MUJA). Manipulation under epidural anesthesia (MUEA) employs an epidural, segmental anesthetic, often with simultaneous epidural steroid injections, followed by spinal manipulation therapy. Other therapies may combine manipulation with cortisone injections into paraspinal tissues or joint spaces.

Spinal manipulation under anesthesia (SMUA) consists of spinal manipulation and stretching procedures performed on the patient after an anesthetic is administered (e.g., mild sedation, general anesthesia) and may be recommended when standard chiropractic care and other conservative measures have been unsuccessful. This is typically performed by chiropractors, osteopathic physicians, and orthopedic physicians along with an anesthesiologist. Theoretically, SMUA is thought to stretch the joint capsules to break up adhesions within the spinal column to allow for greater mobility and reduced back pain; however, this has not been proven in the peer-reviewed literature.

Note: Unless otherwise specified, this policy does not address closed reduction of a fracture or joint dislocation.

CLINICAL EVIDENCE

Manipulation under anesthesia may be performed for a variety of musculoskeletal conditions which may include the ankle, elbow, finger/toe, hip, knee, shoulder, pelvis and pelvic ring fracture, dislocation, diastatis or subluxation, and the spine.

Ankle

No evidence was identified within the evidence-based peer-reviewed literature concerning ankle manipulation under anesthesia for the treatment of any condition.

Elbow

There is little data within the evidence-based, peer reviewed literature concerning the safety and effectiveness of using manipulation under anesthesia of the elbow. Although some studies suggest that it may be useful in the early-post operative recovery of patients with joint contractures, there is a lack of substantial evidence that validates this use.

Araghi and colleagues (2010) have used a technique of elbow examination (manipulation) under anesthesia in select patients. The study comprised 51 consecutive patients who underwent an examination under anesthesia.
Forty-four patients with a minimum of 12 months follow-up revealed a mean pre-examination arc of 33 degrees, which improved to 73 degrees at the final assessment. Three patients had no appreciable change (less than 10 degrees) in the total arc, and 1 patient lost motion. Four patients underwent a second examination under anesthesia at a mean of 119 days after the first examination. The average pre-examination arc of 40 degrees increased to 78 degrees at the final assessment (mean improvement of 38 degrees). The only complication was worsening of ulnar paresthesias in 3 patients; with 2 resolving spontaneously, and 1 requiring anterior ulnar nerve transposition. The authors concluded that because this was not a controlled series, additional studies should be conducted to better identify those not likely to benefit from this procedure. In addition, this study is limited by its small sample size and lack of a control group.

A retrospective review by Tan et al. (2006) looked at 52 patients who underwent open surgical treatment for post-traumatic elbow contracture at an average of 14 months from the time of injury. Indication for operative release was functional loss of elbow arc of motion that failed non-operative therapy and a splinting program. Follow-up was 18.7 months. Of the 52 patients, 14 required closed manipulation under anesthesia, in the early postoperative period. Five patients required a second contracture release at an average of 12 months after the index release. Four patients failed because of painful motion and elbow instability. The authors concluded that recurrence of post-traumatic stiffness in the postoperative period is common but is responsive to manipulation under anesthesia and repeat releases. The relatively small number of patients and lack of randomization and a control group are weaknesses of this study.

Antuna et al. (2002) reported in a study for ulnohumeral arthroplasty for primary degenerative arthritis of the elbow that 2 patients underwent elbow manipulation under anesthesia to improve the range of motion after the ulnohumeral arthroplasty. The indication for this procedure was loss of preoperative motion or of motion attained at surgery. Both patients underwent manipulation twice, and ulnar nerve symptoms developed after the second manipulation. The arc of motion increased 40° in one patient and 45° in the other. However, because of the ulnar symptoms they no longer recommend manipulation of the elbow in the early postoperative period if the nerve has not been decompressed or translocated. They felt that patients with postoperative stiffness after ulnohumeral arthroplasty might be better treated by progressive stretching with static splints.

Chao et al. (2002) reported in a study on surgical approaches for nonneurogenic elbow heterotopic ossification with ulnar neuropathy that forceful and repetitive manipulation may add further damage to an already stiffened elbow and should be avoided after immobilization or surgery.

Gaur (2003) reported on eight children (ten elbows) who were found to have severe heterotopic ossification of the elbow, leading to an inability to reach the mouth for feeding and the head and the perineum for self-care. Excision of the heterotopic ossification was undertaken if the patient had this limitation of function and if movement was restricted to a total arc of motion of <50° Four of the patients underwent a manipulation under anesthesia in the post-operative period. The nine elbows available for follow-up had an improved arc of motion (an average increase of 57° This study is limited by small numbers and lack of any control group or randomization.

Finger
There is little data within the evidence-based, peer reviewed literature concerning the safety and effectiveness of using manipulation under anesthesia of the finger.

A case report of 3 patients by Guly and Azam (1982) reviews the use of manipulation for a locked finger. All 3 patients were treated with manipulation under anesthesia using a local anesthetic injected into the finger joint. Two patients had a locked middle finger and 1 patient had a locked index finger. In each case, the patient was successfully treated with gentle manipulation. This study is limited by small sample size and lack of randomization.

Hip
No studies that provide substantial evidence regarding the use of manipulation under anesthesia of the hip joint were identified.

Knee
The use of knee joint manipulation following total knee arthroplasty appears to be effective as a means of improving flexion of the joint. It also appears that this procedure may lead to a decrease in pain scores as reported within the literature.

Fitzsimmons et al. (2010) conducted a systematic review to compare manipulation under anesthesia (MUA) with arthroscopy and open arthrolysis for knee stiffness following total knee arthroplasty. The review evaluated 14,421 studies of which 23 were deemed relevant. MUA alone resulted in a mean gain in knee motion of 30 to 47 degrees. Range of motion in the arthroscopy group increased between 18.5 to 60 degrees. The open arthrolysis group had less gain in range of motion with gains between 19 and 31 degrees. The authors concluded that both MUA and arthroscopy provide similar gains in range of motion for patients with knee stiffness following total knee arthroplasty. Open athrolysis had less favorable results.

Pariente et al. (2006) conducted a retrospective review on 333 patients who were unable to achieve adequate range of motion after total knee arthroplasty. The study was conducted to compare the efficacy of a modified manipulation technique, which uses epidural anesthesia continued for postoperative analgesia, hospital stay of one to three days, continuous passive motion (CPM) for two to three days, and daily physical therapy (PT) to standard manipulation under anesthesia. Manipulation using a standard technique was performed on 273 patients (334 knees) and manipulation using a modified technique was performed on 60 patients (65 knees). Average follow-up time was 18.4 months. With the modified technique, ROM improved from 71 degrees to 102 degrees, and knee society pain, function, and total clinical scores improved as well. Successful results were observed in 48 (74%) knees with 4 additional knees having a successful result after a subsequent manipulation. The authors concluded that manipulation under epidural anesthesia represents a viable option for treatment of persistent stiffness after total knee arthroplasty.

Keating et al. (2007) studied 90 patients (113 knees) who underwent manipulation for postoperative flexion of < or =90 degrees at a mean of ten weeks after surgery. Flexion was measured with a goniometer prior to total knee arthroplasty, at the conclusion of the operative procedure, before manipulation, immediately after manipulation, at six months, and at one, three, and five years postoperatively. Of the 90 patients, 81 (90%) achieved improvement of ultimate knee flexion following manipulation. The average flexion was 102 degrees prior to total knee

arthroplasty, 111 degrees following skin closure, and 70 degrees before manipulation. There was no significant difference in the mean improvement in flexion when patients who had manipulation within twelve weeks postoperatively were compared with those who had manipulation more than twelve weeks postoperatively. The authors concluded that manipulation generally increases ultimate flexion following total knee arthroplasty and patients with severe preoperative pain are more likely to require manipulation.

Namba and Inacio (2007) reviewed 195 patients who had undergone manipulation under anesthesia; 102 within 90 days of total knee arthroplasty and 93 more than 90 days after total knee arthroplasty. Average pain (10-point scale), satisfaction (10-point scale), flexion (degrees), and extension (degrees) were recorded before and after MUA. Flexion was significantly improved after MUA for both groups: early MUA from 68.4 degrees (+/-17.2 degrees) to 101.4 degrees (+/-16.15 degrees); and late MUA from 81.0 degrees (+/-13.3 degrees) to 98.0 degrees (+/-18.0 degrees). Pain decreased significantly with early MUA from 4.92 (+/-2.25) to 3.34 (+/-2.67) and with late MUA from 4.51 (+/-2.62) to 3.44 (+/-2.78). Extension improved only in the early MUA group from 7.15 (+/-10.1) to 2.50 (+/-4.98). Satisfaction scores were not improved. The authors concluded that both early and late manipulation can improve TKA pain and flexion.

Multiple Joints
Evidence supporting the need for multiple, repeat sessions of MUA for these conditions was not found in the published medical literature.

Pelvis
There is little data within the evidence-based literature to assess the safety and efficacy of pelvic ring manipulation under anesthesia; however, the use of manipulation under anesthesia of the pelvis and/or pelvic ring as a result of fracture(s) or dislocation is an integral part of the restoration of the pelvic ring whether used as part of a closed or open-reduction surgical technique (Hayes, 2008).

No literature was found to support manipulation under anesthesia of the pelvis for diastasis or subluxation.

Shoulder
The use of shoulder manipulation under anesthesia to reduce pain and improve range of motion appears to be effective in patients with adhesive capsulitis (frozen shoulder) when conservative non-surgical treatment has failed.

A blinded, randomized trial with a 1 year follow-up, by Kivimaki et al. (2007) evaluated 125 patients with a frozen shoulder to determine the effect of manipulation under anesthesia. Patients were randomly assigned to either a manipulation group (65 patients) or a control group (60 patients). Both the intervention group and the control group were instructed in specific therapeutic exercises by physiotherapists. Clinical data was gathered at baseline and at 6 weeks and 3, 6, and 12 months after randomization. The 2 groups did not differ at any time of the follow-up in terms of shoulder pain or working ability. Small differences in the range of movement were detected in favor of the manipulation group. Perceived shoulder pain decreased during follow-up equally in the 2 groups, and at 1 year after randomization, only slight pain remained. The authors concluded that manipulation under anesthesia does not add effectiveness to an exercise program carried out by the patient after instruction.

Ng et al. (2009) conducted a prospective trial of 50 patients to examine the efficacy of manipulation under anaesthesia (MUA) followed by early physiotherapy in treating frozen shoulder syndrome. Disabilities of the Arm, Shoulder and Hand (DASH) score and visual analogue score (VAS) for pain and range of movement were measured preoperatively and at 6 weeks post-procedure. The mean DASH score decreased from 48.07 to 15.84 and the mean VAS reduced from 6.07 to 1.88. Flexion improved from 104.18 to 157.56; abduction from 70.48 to 150.00; and external rotation from 13.88 to 45.62. The authors concluded that MUA combined

with early physiotherapy alleviates pain and facilitates recovery of function in patients with frozen shoulder syndrome.

In a prospective trial conducted between 2001 and 2003 by Loew et al. (2005), 30 patients with primary frozen shoulder manipulated under general anesthesia were evaluated for post manipulative intra-articular lesions. Patients with secondary stiffness caused by rotator cuff tears and glenohumeral arthritis were excluded. Arthroscopy was used after manipulation to document any intra-articular lesions. All patients noted an improvement in range of motion. Flexion improved on average from 70 degrees (+/- 33 degrees) to 180 degrees (+/- 15 degrees), abduction from 50 degrees (+/- 20 degrees) to 170 degrees (+/- 25 degrees), and external rotation from -5 degrees (+/- 10 degrees) to +40 degrees (+/- 20 degrees). Localized synovitis was detected in 22 of the patients in the area of the rotator interval, whereas disseminated synovitis was observed in 8 patients. After manipulation, the capsule was seen to be ruptured superiorly in 11 patients, the anterior capsule was ruptured up to the infraglenoid pole in 24 patients, and 16 patients each had a capsular lesion located posteriorly. In 18 patients no additional joint damage was found and in 4 patients, iatrogenic superior labrum anterior-posterior lesions were observed. The authors concluded that even though manipulation under anesthesia is effective in terms of joint mobilization, the method can cause iatrogenic intra-articular damage.

Flannery et al. (2007) evaluated 180 consecutive patients to determine what influence timing of manipulation under anesthesia (MUA) had on long-term outcomes for adhesive capsulitis of the shoulder. Of the 180 patients, 145 were available for follow-up after a mean period of 62 months (range of 12 to 125). All patients underwent MUA with intra-articular steroid injection. Improvement was noted in range of motion and function utilizing the Oxford Shoulder Score (OSS) and Visual Analogue Score (VAS) following manipulation. Eighty-three percent of the patients had MUA performed less than 9 months from onset of symptoms (early MUA). The remainder had MUA performed 9 to 40 months (late MUA) from onset of symptoms. The authors found that both groups had better mobility and Oxford Shoulder Score as well as less pain; however the early intervention group had the most improvement.

In a study by Farrell et al. (2005), manipulation under anesthesia was performed in 25 patients (26 shoulders) for whom non-operative treatment for idiopathic frozen shoulder had failed. All of the patients had physical therapy for a mean of 6.2 months. Long-term follow-up was obtained in 18 patients (19 shoulders) by questionnaire and averaged 15 years (range, 8.1 to 20.6 years). There were significant improvements in forward elevation from a mean of 104 degrees before manipulation to 168 degrees and in external rotation from 23 degrees to 67 degrees. There were 16 shoulders with no pain or slight pain and 3 with occasional moderate or severe pain. Of the 19 shoulders, 18 required no further surgery. The mean Simple Shoulder Test score was 9.5 out of 12 and the mean American Shoulder and Elbow Surgeons score was 80 out of 100. The authors conclude that treatment of idiopathic frozen shoulder by manipulation under anesthesia leads to sustained improvement in shoulder motion and function at a mean of 15 years after the procedure.

Spine
There are several studies in evidence based peer-reviewed literature which recommend that additional studies are needed to support the safety and effectiveness of spinal manipulation under anesthesia.

In a prospective study of 68 chronic low-back pain patients, Kohlbeck et al. (2005) compared changes in pain and disability for chronic low-back pain patients receiving treatment with medication-assisted manipulation (MAM) to patients receiving spinal manipulation only. All patients received an initial 4- to 6-week trial of spinal manipulation therapy (SMT), after which 42 patients received supplemental intervention with MAM and the remaining 26 patients continued with SMT. Low back pain and disability measures favored the MAM group over the SMT-only group at 3 months. The authors concluded that medication-assisted manipulation appears to offer some patients increased improvement in low back pain and disability; however the study is limited

by lack of randomization, small sample size and significant baseline differences between groups for the primary outcome variable (pain/disability scale).

In a prospective controlled study by Palmieri and Smoyak (2002), 87 patients who received either spinal manipulation under anesthesia (SMUA) or traditional chiropractic treatment for low back pain were evaluated. The participants were assigned to one of two groups: 38 to an intervention group who received MUA and 49 patients to a nonintervention group who received traditional chiropractic treatment. Patients were followed for 4 weeks. Self-reported outcomes, including back pain severity and functional status, were used to evaluate changes. The MUA group had an average decrease of 50% in the Numeric Pain Scale scores while the nonintervention group had a 26% decrease. The MUA group had an average decrease of 51% in the Roland-Morris Questionnaire scores while the nonintervention group had a 38% decrease. The authors concluded that while there was greater improvement in the intervention group, additional studies are needed to evaluate the safety and effectiveness of MUA.

This study is flawed due to the methods used to select subjects, lack of assessor blinding, failure to isolate the effects of the active intervention, and interpretation of outcomes. Subjects were selected largely based upon 2 criteria: meeting NAMUAP eligibility requirements and having insurance coverage for MUA. This led to significant baseline heterogeneities between intervention and control groups. Sample size (N=87; MUA group = 38; SMT group = 49) did not reach anticipated number of participants. The attempt to measure the difference in treatment effect between MUA and SMT was confounded by the addition of a specific exercise protocol for the MUA group vs. an undefined "home exercise" program for the SMT group. Follow-up period was limited. Problems with obtaining timely follow-up data were reported. The use of a percentile difference in outcome scores between groups does not take into account if each outcome of interest exhibited a clinically meaningful difference between each group. In fact, there were no statistical or clinically meaningful differences between groups. There was a difference of 1.52 points on the NRS at initial follow-up and 1.32 points difference at final follow-up (the minimal clinically important change has been widely reported as 2 points). The difference at initial follow-up for the RMDQ was 2.2 points and at final follow-up was 1 point (as noted in the study, a 4 point difference is necessary for it to be clinically meaningful).

Cremata et al. (2005) reported the results of manipulation under anesthesia (MUA) for 4 patients with chronic spinal, sacroiliac, and/or pelvic and low back pain. Patients with chronic pain who had not adequately responded to conservative medical and/or a reasonable trial (4 months minimum) of chiropractic adjustments, and had no contraindications to anesthesia or adjustments, were selected. The 4 patients went through 3 consecutive days of MUA followed by an 8-week protocol of the same procedures plus physiotherapy in-office without anesthesia. Data included pre- and post-MUA passive ranges of motion, changes in the visual analog scale, neurologic and orthopedic examination findings. The patients had follow-up varying from 9 to 18 months and showed improvement in passive ranges of motion, decreases in the visual analog scale rating, and diminishment of subsequent visit frequency. The authors concluded that manipulation under anesthesia was an effective approach to restoring articular and myofascial movements in patients who did not adequately respond to either medical in-office conservative chiropractic adjustments and/or adjunctive techniques. Weaknesses of this study include small sample size and lack of randomization. Additional studies are needed to evaluate the safety and effectiveness of spinal MUA.

A descriptive case series reported on the outcomes of 177 subjects, who met a set of inclusion criteria, which included prior failed response to conventional manipulation (2-6 weeks trial) (West, 1999). All subjects underwent three serial MUAs. Post-MUA results included increased range of motion and clinically meaningful pain reduction. Both these outcomes showed continued improvement at 6-months follow-up. Unfortunately, the study design was incompatible with the objective of establishing a causal relationship i.e., the efficacy of MUA for a selected population. Additionally, an attempt to measure the strength of association of MUA with the outcomes was confounded by the inclusion of a broad range of other interventions rendered within the

framework of this study. Interventions reportedly included: passive modalities, different types of exercise, as well as traditional spinal manipulative therapy.

Temporomandibular Joint (TMJ)
Available evidence for manipulation under anesthesia for temporomandibular joint syndrome is limited to small, uncontrolled studies with limited follow-up.

Foster et al. (2000) studied 55 patients receiving manipulation under general anesthesia of the temporomandibular joint to determine the success rate of MUA effectiveness in an effort to reduce the number of patients being referred for invasive surgery. Of the 55 patients participating in this study, 15 improved, 15 did not, 6 showed partial improvement and 19 were not treated. The median pre-treatment opening was 20mm (range 13-27). Among those who improved after manipulation, the median opening after treatment was 38mm (range 35-56). The authors concluded that MUA may help some patients; however, some of those who improved experienced a return of TMJ clicking but not of joint or muscle tenderness.

Toe
No evidence was identified within the evidence-based peer-reviewed literature concerning manipulation under anesthesia of the toe.

Wrist
Available evidence for manipulation under anesthesia for wrist is limited to small, uncontrolled studies with limited follow-up or case studies.

Hanson et al. (1988) reported on 10 patients having thickening and contracture of the wrist joint capsule. Four of the 10 patients required manipulation under anesthesia which resulted in some improvement in range of motion. The authors note that while manipulation under anesthesia may be promising, careful technique and judicious patient selection are of paramount importance. Small sample size, lack of randomization, and no indication of follow-up are limitations of this study.

Professional Societies
The **International Chiropractors Association (ICA)**, in its 2000 publication *Recommended Clinical Protocols And Guidelines For The Practice Of Chiropractic*, ICA states that within the armamentarium of chiropractic techniques, efficient methods exist that address the pain profiles of even the most sensitive patient. Furthermore, the chiropractic adjustment relies on the body's own inherent constructive survival mechanisms to innately accomplish adjusted correction. In light of the above considerations, the International Chiropractors Association holds that anesthesia is inappropriate and unnecessary to the deliverance of a chiropractic adjustment.

The **International MUA Academy of Physicians** lists the following general indications for manipulation under anesthesia (IMUAA, 2006):

- Fibro adhesion buildup
- Chronic disc problems
- Herniated disc without fragmentation
- Chronic myofascitis
- Intractable pain from neuromusculoskeletal conditions
- Torticollis
- Chronic re-injury
- Failed back surgery

According to the **American College of Occupational and Environmental Medicine (ACOEM)** practice guidelines regarding physical methods of treatment for low back disorders (Hegmann, 2007;update: Hegmann, et al., 2008), due to insufficient evidence manipulation under anesthesia

(MUA) and medication-assisted spinal manipulation (MASM) for acute, subacute or chronic low back pain is not recommended.

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

Manipulation is a procedure and therefore not subject to FDA regulation.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Medicare does not have a National Coverage Determination (NCD) for manipulation under anesthesia. Local Coverage Determinations (LCDs) for Manipulation Under Anesthesia (MUA), exist and compliance with these policies is required where applicable. (Accessed January 11, 2012)

APPLICABLE CODES

The codes listed in this policy are for reference purposes only. Listing of a service or device code in this policy does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the benefit document. This list of codes may not be all inclusive.

CPT® Code	Description
21073	Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (i.e., general or monitored anesthesia care)
22505	Manipulation of spine requiring anesthesia, any region
23700	Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)
24300	Manipulation, elbow, under anesthesia
25259	Manipulation, wrist, under anesthesia
26340	Manipulation, finger joint, under anesthesia, each joint
27194	Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; with manipulation, requiring more than local anesthesia
27275	Manipulation, hip joint, requiring general anesthesia
27570	Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices)
27860	Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus)

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ICD-9 Code (Proven)	Description
718.51	Ankylosis of joint of shoulder region
718.52	Ankylosis of upper arm joint
718.56	Ankylosis of lower leg joint
726.0	Adhesive capsulitis of shoulder
726.10	Unspecified disorders of bursae and tendons in shoulder region
726.11	Calcifying tendinitis of shoulder
733.19	Pathologic fracture of other specified site
805.6	Closed fracture of sacrum and coccyx without mention of spinal cord injury
806.61	Closed fracture of sacrum and coccyx with complete cauda equina lesion
806.62	Closed fracture of sacrum and coccyx with other cauda equina injury

806.79	Open fracture of sacrum and coccyx with other spinal cord injury
808.0	Closed fracture of acetabulum
808.2	Closed fracture of pubis
808.41	Closed fracture of ilium
808.42	Closed fracture of ischium
808.43	Multiple closed pelvic fractures with disruption of pelvic circle
808.44	Multiple closed pelvic fractures without disruption of pelvic circle
808.49	Closed fracture of other specified part of pelvis
808.53	Multiple open pelvic fractures with disruption of pelvic circle
808.54	Multiple open pelvic fractures without disruption of pelvic circle
839.41	Closed dislocation, coccyx
839.42	Closed dislocation, sacrum

ICD-10 Codes (Preview Draft)
In preparation for the transition from ICD-9 to ICD-10 medical coding on October 1, 2014*, a sample listing of the ICD-10 CM and/or ICD-10 PCS codes associated with this policy has been provided below for your reference. This list of codes may not be all inclusive and will be updated to reflect any applicable revisions to the ICD-10 code set and/or clinical guidelines outlined in this policy. **The effective date for ICD-10 code set implementation is subject to change.*

ICD-10 Diagnosis Code (Effective 10/01/14)	Description
M24.611	Ankylosis, right shoulder
M24.612	Ankylosis, left shoulder
M24.619	Ankylosis, unspecified shoulder
M24.621	Ankylosis, right elbow
M24.622	Ankylosis, left elbow
M24.629	Ankylosis, unspecified elbow
M24.661	Ankylosis, right knee
M24.662	Ankylosis, left knee
M24.669	Ankylosis, unspecified knee
M66.211	Spontaneous rupture of extensor tendons, right shoulder
M66.212	Spontaneous rupture of extensor tendons, left shoulder
M66.219	Spontaneous rupture of extensor tendons, unspecified shoulder
M66.811	Spontaneous rupture of other tendons, right shoulder
M66.812	Spontaneous rupture of other tendons, left shoulder
M66.819	Spontaneous rupture of other tendons, unspecified shoulder
M75.00	Adhesive capsulitis of unspecified shoulder
M75.01	Adhesive capsulitis of right shoulder
M75.02	Adhesive capsulitis of left shoulder
M75.100	Unspecified rotator cuff tear or rupture of unspecified shoulder, not specified as traumatic
M75.101	Unspecified rotator cuff tear or rupture of right shoulder, not specified as traumatic
M75.102	Unspecified rotator cuff tear or rupture of left shoulder, not specified as traumatic
M75.30	Calcific tendinitis of unspecified shoulder
M75.31	Calcific tendinitis of right shoulder
M75.32	Calcific tendinitis of left shoulder
M75.50	Bursitis of unspecified shoulder
M75.51	Bursitis of right shoulder
M75.52	Bursitis of left shoulder
M80.011A	Age-related osteoporosis with current pathological fracture, right shoulder, initial encounter for fracture

M80.012A	Age-related osteoporosis with current pathological fracture, left shoulder, initial encounter for fracture
M80.019A	Age-related osteoporosis with current pathological fracture, unspecified shoulder, initial encounter for fracture
M80.041A	Age-related osteoporosis with current pathological fracture, right hand, initial encounter for fracture
M80.042A	Age-related osteoporosis with current pathological fracture, left hand, initial encounter for fracture
M80.049A	Age-related osteoporosis with current pathological fracture, unspecified hand, initial encounter for fracture
M80.811A	Other osteoporosis with current pathological fracture, right shoulder, initial encounter for fracture
M80.812A	Other osteoporosis with current pathological fracture, left shoulder, initial encounter for fracture
M80.819A	Other osteoporosis with current pathological fracture, unspecified shoulder, initial encounter for fracture
M80.841A	Other osteoporosis with current pathological fracture, right hand, initial encounter for fracture
M80.842A	Other osteoporosis with current pathological fracture, left hand, initial encounter for fracture
M80.849A	Other osteoporosis with current pathological fracture, unspecified hand, initial encounter for fracture
M84.411A	Pathological fracture, right shoulder, initial encounter for fracture
M84.412A	Pathological fracture, left shoulder, initial encounter for fracture
M84.419A	Pathological fracture, unspecified shoulder, initial encounter for fracture
M84.441A	Pathological fracture, right hand, initial encounter for fracture
M84.442A	Pathological fracture, left hand, initial encounter for fracture
M84.443A	Pathological fracture, unspecified hand, initial encounter for fracture
M84.444A	Pathological fracture, right finger(s), initial encounter for fracture
M84.445A	Pathological fracture, left finger(s), initial encounter for fracture
M84.446A	Pathological fracture, unspecified finger(s), initial encounter for fracture
M84.454A	Pathological fracture, pelvis, initial encounter for fracture
M84.474A	Pathological fracture, right foot, initial encounter for fracture
M84.475A	Pathological fracture, left foot, initial encounter for fracture
M84.476A	Pathological fracture, unspecified foot, initial encounter for fracture
M84.477A	Pathological fracture, right toe(s), initial encounter for fracture
M84.478A	Pathological fracture, left toe(s), initial encounter for fracture
M84.479A	Pathological fracture, unspecified toe(s), initial encounter for fracture
M84.48XA	Pathological fracture, other site, initial encounter for fracture
M84.511A	Pathological fracture in neoplastic disease, right shoulder, initial encounter for fracture
M84.512A	Pathological fracture in neoplastic disease, left shoulder, initial encounter for fracture
M84.519A	Pathological fracture in neoplastic disease, unspecified shoulder, initial encounter for fracture
M84.541A	Pathological fracture in neoplastic disease, right hand, initial encounter for fracture
M84.542A	Pathological fracture in neoplastic disease, left hand, initial encounter for fracture
M84.549A	Pathological fracture in neoplastic disease, unspecified hand, initial encounter for fracture
M84.550A	Pathological fracture in neoplastic disease, pelvis, initial encounter

	for fracture
M84.574A	Pathological fracture in neoplastic disease, right foot, initial encounter for fracture
M84.575A	Pathological fracture in neoplastic disease, left foot, initial encounter for fracture
M84.576A	Pathological fracture in neoplastic disease, unspecified foot, initial encounter for fracture
M84.611A	Pathological fracture in other disease, right shoulder, initial encounter for fracture
M84.612A	Pathological fracture in other disease, left shoulder, initial encounter for fracture
M84.619A	Pathological fracture in other disease, unspecified shoulder, initial encounter for fracture
M84.641A	Pathological fracture in other disease, right hand, initial encounter for fracture
M84.642A	Pathological fracture in other disease, left hand, initial encounter for fracture
M84.649A	Pathological fracture in other disease, unspecified hand, initial encounter for fracture
M84.650A	Pathological fracture in other disease, pelvis, initial encounter for fracture
M84.674A	Pathological fracture in other disease, right foot, initial encounter for fracture
M84.675A	Pathological fracture in other disease, left foot, initial encounter for fracture
M84.676A	Pathological fracture in other disease, unspecified foot, initial encounter for fracture
M84.68XA	Pathological fracture in other disease, other site, initial encounter for fracture
M99.14	Subluxation complex (vertebral) of sacral region
S32.10XA	Unspecified fracture of sacrum, initial encounter for closed fracture
S32.10XB	Unspecified fracture of sacrum, initial encounter for open fracture
S32.110A	Nondisplaced Zone I fracture of sacrum, initial encounter for closed fracture
S32.111A	Minimally displaced Zone I fracture of sacrum, initial encounter for closed fracture
S32.112A	Severely displaced Zone I fracture of sacrum, initial encounter for closed fracture
S32.119A	Unspecified Zone I fracture of sacrum, initial encounter for closed fracture
S32.120A	Nondisplaced Zone II fracture of sacrum, initial encounter for closed fracture
S32.121A	Minimally displaced Zone II fracture of sacrum, initial encounter for closed fracture
S32.122A	Severely displaced Zone II fracture of sacrum, initial encounter for closed fracture
S32.129A	Unspecified Zone II fracture of sacrum, initial encounter for closed fracture
S32.130A	Nondisplaced Zone III fracture of sacrum, initial encounter for closed fracture
S32.131A	Minimally displaced Zone III fracture of sacrum, initial encounter for closed fracture
S32.132A	Severely displaced Zone III fracture of sacrum, initial encounter for closed fracture
S32.139A	Unspecified Zone III fracture of sacrum, initial encounter for closed

	fracture
S32.14XA	Type 1 fracture of sacrum, initial encounter for closed fracture
S32.15XA	Type 2 fracture of sacrum, initial encounter for closed fracture
S32.16XA	Type 3 fracture of sacrum, initial encounter for closed fracture
S32.17XA	Type 4 fracture of sacrum, initial encounter for closed fracture
S32.19XA	Other fracture of sacrum; initial encounter for closed fracture
S32.2XXA	Fracture of coccyx, initial encounter for closed fracture
S32.2XXB	Fracture of coccyx, initial encounter for open fracture
S32.301A	Unspecified fracture of right ilium, initial encounter for closed fracture
S32.302A	Unspecified fracture of left ilium, initial encounter for closed fracture
S32.309A	Unspecified fracture of unspecified ilium, initial encounter for closed fracture
S32.311A	Displaced avulsion fracture of right ilium, initial encounter for closed fracture
S32.312A	Displaced avulsion fracture of left ilium, initial encounter for closed fracture
S32.313A	Displaced avulsion fracture of unspecified ilium, initial encounter for closed fracture
S32.314A	Nondisplaced avulsion fracture of right ilium, initial encounter for closed fracture
S32.315A	Nondisplaced avulsion fracture of left ilium, initial encounter for closed fracture
S32.316A	Nondisplaced avulsion fracture of unspecified ilium, initial encounter for closed fracture
S32.391A	Other fracture of right ilium, initial encounter for closed fracture
S32.392A	Other fracture of left ilium, initial encounter for closed fracture
S32.399A	Other fracture of unspecified ilium, initial encounter for closed fracture
S32.401A	Unspecified fracture of right acetabulum, initial encounter for closed fracture
S32.402A	Unspecified fracture of left acetabulum, initial encounter for closed fracture
S32.409A	Unspecified fracture of unspecified acetabulum, initial encounter for closed fracture
S32.411A	Displaced fracture of anterior wall of right acetabulum, initial encounter for closed fracture
S32.412A	Displaced fracture of anterior wall of left acetabulum, initial encounter for closed fracture
S32.413A	Displaced fracture of anterior wall of unspecified acetabulum, initial encounter for closed fracture
S32.414A	Nondisplaced fracture of anterior wall of right acetabulum, initial encounter for closed fracture
S32.415A	Nondisplaced fracture of anterior wall of left acetabulum, initial encounter for closed fracture
S32.416A	Nondisplaced fracture of anterior wall of unspecified acetabulum, initial encounter for closed fracture
S32.421A	Displaced fracture of posterior wall of right acetabulum, initial encounter for closed fracture
S32.422A	Displaced fracture of posterior wall of left acetabulum, initial encounter for closed fracture
S32.423A	Displaced fracture of posterior wall of unspecified acetabulum, initial encounter for closed fracture
S32.424A	Nondisplaced fracture of posterior wall of right acetabulum, initial encounter for closed fracture

S32.425A	Nondisplaced fracture of posterior wall of left acetabulum, initial encounter for closed fracture
S32.426A	Nondisplaced fracture of posterior wall of unspecified acetabulum, initial encounter for closed fracture
S32.431A	Displaced fracture of anterior column [iliopubic] of right acetabulum, initial encounter for closed fracture
S32.432A	Displaced fracture of anterior column [iliopubic] of left acetabulum, initial encounter for closed fracture
S32.433A	Displaced fracture of anterior column [iliopubic] of unspecified acetabulum, initial encounter for closed fracture
S32.434A	Nondisplaced fracture of anterior column [iliopubic] of right acetabulum, initial encounter for closed fracture
S32.435A	Nondisplaced fracture of anterior column [iliopubic] of left acetabulum, initial encounter for closed fracture
S32.436A	Nondisplaced fracture of anterior column [iliopubic] of unspecified acetabulum, initial encounter for closed fracture
S32.441A	Displaced fracture of posterior column [ilioischial] of right acetabulum, initial encounter for closed fracture
S32.442A	Displaced fracture of posterior column [ilioischial] of left acetabulum, initial encounter for closed fracture
S32.443A	Displaced fracture of posterior column [ilioischial] of unspecified acetabulum, initial encounter for closed fracture
S32.444A	Nondisplaced fracture of posterior column [ilioischial] of right acetabulum, initial encounter for closed fracture
S32.445A	Nondisplaced fracture of posterior column [ilioischial] of left acetabulum, initial encounter for closed fracture
S32.446A	Nondisplaced fracture of posterior column [ilioischial] of unspecified acetabulum, initial encounter for closed fracture
S32.451A	Displaced transverse fracture of right acetabulum, initial encounter for closed fracture
S32.452A	Displaced transverse fracture of left acetabulum, initial encounter for closed fracture
S32.453A	Displaced transverse fracture of unspecified acetabulum, initial encounter for closed fracture
S32.454A	Nondisplaced transverse fracture of right acetabulum, initial encounter for closed fracture
S32.455A	Nondisplaced transverse fracture of left acetabulum, initial encounter for closed fracture
S32.456A	Nondisplaced transverse fracture of unspecified acetabulum, initial encounter for closed fracture
S32.461A	Displaced associated transverse-posterior fracture of right acetabulum, initial encounter for closed fracture
S32.462A	Displaced associated transverse-posterior fracture of left acetabulum, initial encounter for closed fracture
S32.463A	Displaced associated transverse-posterior fracture of unspecified acetabulum, initial encounter for closed fracture
S32.464A	Nondisplaced associated transverse-posterior fracture of right acetabulum, initial encounter for closed fracture
S32.465A	Nondisplaced associated transverse-posterior fracture of left acetabulum, initial encounter for closed fracture
S32.466A	Nondisplaced associated transverse-posterior fracture of unspecified acetabulum, initial encounter for closed fracture
S32.471A	Displaced fracture of medial wall of right acetabulum, initial encounter for closed fracture
S32.472A	Displaced fracture of medial wall of left acetabulum, initial encounter

	for closed fracture
S32.473A	Displaced fracture of medial wall of unspecified acetabulum, initial encounter for closed fracture
S32.474A	Nondisplaced fracture of medial wall of right acetabulum, initial encounter for closed fracture
S32.475A	Nondisplaced fracture of medial wall of left acetabulum, initial encounter for closed fracture
S32.476A	Nondisplaced fracture of medial wall of unspecified acetabulum, initial encounter for closed fracture
S32.481A	Displaced dome fracture of right acetabulum, initial encounter for closed fracture
S32.482A	Displaced dome fracture of left acetabulum, initial encounter for closed fracture
S32.483A	Displaced dome fracture of unspecified acetabulum, initial encounter for closed fracture
S32.484A	Nondisplaced dome fracture of right acetabulum, initial encounter for closed fracture
S32.485A	Nondisplaced dome fracture of left acetabulum, initial encounter for closed fracture
S32.486A	Nondisplaced dome fracture of unspecified acetabulum, initial encounter for closed fracture
S32.491A	Other specified fracture of right acetabulum, initial encounter for closed fracture
S32.492A	Other specified fracture of left acetabulum, initial encounter for closed fracture
S32.499A	Other specified fracture of unspecified acetabulum, initial encounter for closed fracture
S32.501A	Unspecified fracture of right pubis, initial encounter for closed fracture
S32.502A	Unspecified fracture of left pubis, initial encounter for closed fracture
S32.509A	Unspecified fracture of unspecified pubis, initial encounter for closed fracture
S32.511A	Fracture of superior rim of right pubis, initial encounter for closed fracture
S32.512A	Fracture of superior rim of left pubis, initial encounter for closed fracture
S32.519A	Fracture of superior rim of unspecified pubis, initial encounter for closed fracture
S32.591A	Other specified fracture of right pubis, initial encounter for closed fracture
S32.592A	Other specified fracture of left pubis, initial encounter for closed fracture
S32.599A	Other specified fracture of unspecified pubis, initial encounter for closed fracture
S32.601A	Unspecified fracture of right ischium, initial encounter for closed fracture
S32.602A	Unspecified fracture of left ischium, initial encounter for closed fracture
S32.609A	Unspecified fracture of unspecified ischium, initial encounter for closed fracture
S32.611A	Displaced avulsion fracture of right ischium, initial encounter for closed fracture
S32.612A	Displaced avulsion fracture of left ischium, initial encounter for closed fracture
S32.613A	Displaced avulsion fracture of unspecified ischium, initial encounter

	for closed fracture
S32.614A	Nondisplaced avulsion fracture of right ischium, initial encounter for closed fracture
S32.615A	Nondisplaced avulsion fracture of left ischium, initial encounter for closed fracture
S32.616A	Nondisplaced avulsion fracture of unspecified ischium, initial encounter for closed fracture
S32.691A	Other specified fracture of right ischium, initial encounter for closed fracture
S32.692A	Other specified fracture of left ischium, initial encounter for closed fracture
S32.699A	Other specified fracture of unspecified ischium, initial encounter for closed fracture
S32.810A	Multiple fractures of pelvis with stable disruption of pelvic ring, initial encounter for closed fracture
S32.810B	Multiple fractures of pelvis with stable disruption of pelvic ring, initial encounter for open fracture
S32.811A	Multiple fractures of pelvis with unstable disruption of pelvic ring, initial encounter for closed fracture
S32.811B	Multiple fractures of pelvis with unstable disruption of pelvic ring, initial encounter for open fracture
S32.82XA	Multiple fractures of pelvis without disruption of pelvic ring, initial encounter for closed fracture
S32.82XB	Multiple fractures of pelvis without disruption of pelvic ring, initial encounter for open fracture
S32.89XA	Fracture of other parts of pelvis, initial encounter for closed fracture
S32.9XXA	Fracture of unspecified parts of lumbosacral spine and pelvis, initial encounter for closed fracture
S33.2XXA	Dislocation of sacroiliac and sacrococcygeal joint, initial encounter
S34.131A	Complete lesion of sacral spinal cord, initial encounter
S34.132A	Incomplete lesion of sacral spinal cord, initial encounter
S34.3XXA	Injury of cauda equina, initial encounter

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POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
09/01/2012	• Added list of applicable ICD-10 codes (preview draft) in preparation for the transition from ICD-9 to ICD-10 medical coding on 10/01/14
05/01/2012	• Updated description of services to reflect most current clinical evidence, CMS information and references; no change to coverage rationale • Updated list of applicable (proven) ICD-9 diagnosis codes; added 808.44 and 808.53 • Archived previous policy version 2011T0515E

BlueCross BlueShield of Tennessee Medical Policy Manual

Manipulation of Musculoskeletal System Under Anesthesia (General, Mild Sedation and Local)

DESCRIPTION

Manipulation under anesthesia (MUA) consists of passive movements and stretching of joints performed while the individual receives anesthesia (usually short acting anesthetics or moderate sedation).

Manipulation refers to a variety of manual adjustment techniques and is believed to ease pressure on nerves, break up fibrous scar tissue or restore normal musculoskeletal alignment to relieve pain and improve range of motion. Anesthesia or sedation is used to lessen pain, spasm and the conscious reflex muscle guarding; thereby reducing resistance and apprehension for the individual and enhance the therapeutic effects of the joint manipulation through a full range of motion. Manipulation procedures can be offered under general anesthesia, during mild sedation, or following the injection of anesthetic solutions (i.e. local anesthetic agent) into specific areas of the spine or joints. Typically, MUA is an alternative to conservative treatments that have lasted at least six to eight weeks without relieving pain or promoting a return to normal function.

Spinal manipulation under anesthesia has been used in the treatment of acute and chronic back and neck pain where there has been limited success of prior attempts to manipulate the spine. In MUA, a low velocity/high amplitude technique may be used in contrast to the high velocity/low amplitude technique that is used in the typical chiropractic/osteopathic adjustment.

MUA has also been used as a treatment for fibroarthrosis following total knee replacement, in refractory cases of adhesive capsulitis (frozen shoulder), in the setting of displaced fractures and complete joint dislocations, and for temporomandibular joint syndrome.

POLICY

- Manipulation under anesthesia is considered ***medically necessary*** if the medical appropriateness criteria are met. **(See Medical Appropriateness below).**
- Manipulation under anesthesia for other joints including the wrist, elbow, hand, finger, ankle, and pelvis, in the absence of fracture or complete dislocation, is considered ***investigational.***
- Spinal manipulation under anesthesia, (e.g. general anesthesia, joint anesthesia, epidural anesthesia with corticosteroid injections) as a treatment for conditions including, but not limited to chronic spinal pain (e.g. cranial, cervical, thoracic, and lumbar) and chronic sacroiliac and pelvic pain, is considered ***investigational.***
- Spinal manipulation and manipulation of other joints under anesthesia involving serial treatment sessions (greater than 1 treatment) is considered ***investigational.***

See also:

- Intravenous Anesthetics for the Treatment of Chronic Pain
- Modified Condylotomy for Treatment of Temporomandibular Joint (TMJ) Disorders
- Orthognathic Surgery
- Temporomandibular Joint (TMJ) Arthroscopy

MEDICAL APPROPRIATENESS

- Manipulation under anesthesia is considered **medically appropriate** if ANY ONE of the following criteria are met:
    - Treatment of adhesive capsulitis that has failed at least 3 months of conservative interventions (e.g. physical therapy, patient directed exercise, NSAIDS, and/or steroid injections)

- Arthrofibrosis of the knee following total knee arthroplasty, knee surgery, or fracture
- Temporomandibular joint disorder
- Closed reduction of displaced fracture
- Complete joint dislocation

IMPORTANT REMINDER

We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member's health plan must be reviewed. If there is a conflict between the Medical Policy and a health plan, the express terms of the health plan will govern.

ADDITIONAL INFORMATION

As with any treatment of pain, controlled clinical trials are considered particularly important to isolate the contribution of the intervention and to assess the extent of the expected placebo effect. A search of the published medical literature did not identify any controlled clinical trials. Several case series were identified, which included individuals with cervical, thoracic and lumbar back pain, treated according to varying protocols.

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ORIGINAL EFFECTIVE DATE: 8/1/2002

MOST RECENT REVIEW DATE: 5/14/2011

ID_BT

Find Shortage Areas: MUA/P by State and County

Shortage Designation Home
Find Shortage Areas
HPSA & MUA/P by Address
HPSA by State & County
HPSA Eligible for the Medicare Physician Bonus Payment

Criteria:
State: Tennessee
County: Davidson County
ID #: All

Results: 42 records found.

Name	ID#	Type	Score	Designation Date	Update Date
Davidson County					
Bordeaux/Inglewood	03242	MUA	61.00	1994/05/04	2008/03/27
CT 0101.05					
CT 0101.06					
CT 0109.03					
CT 0109.04					
CT 0110.01					
CT 0110.02					
CT 0113.00					
CT 0114.00					
CT 0117.00					
CT 0118.00					
CT 0119.00					
CT 0121.00					
CT 0122.00					
CT 0126.00					
CT 0127.01					
CT 0127.02					
CT 0128.01					
CT 0128.02					
CT 0192.00					
CT 0193.00					
Davidson Service Area	03243	MUA	48.27	1982/05/10	1994/05/04
CT 0160.00					
CT 0161.00					
CT 0162.00					
CT 0163.00					
CT 0164.00					
CT 0168.00					
CT 0169.00					
CT 0170.00					
CT 0171.00					
Davidson Service Area	03248	MUA	57.06	1994/07/12	
CT 0136.01					
CT 0136.02					
CT 0137.00					
CT 0139.00					
CT 0142.00					
CT 0143.00					
CT 0144.00					
CT 0148.00					
CT 0194.00					
CT 0195.00					

NEW SEARCH MODIFY SEARCH CRITERIA

Find Shortage Areas: MUA/P by State and County

Shortage Designation Home

Find Shortage Areas

HPSA & MUA/P by Address

HPSA by State & County

HPSA Eligible for the Medicare Physician Bonus Payment

Criteria:
State: Tennessee
County: Franklin County
ID #: All

Results: 2 records found.

Name	ID#	Type	Score	Designation Date	Update Date
Franklin County					
Franklin Service Area	03191	MUA	44.70	1978/11/01	
MCD (?) Unknown					

NEW SEARCH MODIFY SEARCH CRITERIA

Find Shortage Areas: MUA/P by State and County

Shortage Designation Home

Find Shortage Areas

HPSA & MUA/P by Address

HPSA by State & County

HPSA Eligible for the Medicare Physician Bonus Payment

Criteria:
State: Tennessee
County: Robertson County
ID #: All

Results: 2 records found.

Name	ID#	Type	Score	Designation Date	Update Date
Robertson County					
Robertson Service Area	03228	MUA	60.90	1978/11/01	
MCD (?) Unknown					

NEW SEARCH MODIFY SEARCH CRITERIA

Find Shortage Areas: MUA/P by State and County

Shortage Designation Home

Find Shortage Areas

HPSA & MUA/P by Address

HPSA by State & County

HPSA Eligible for the Medicare Physician Bonus Payment

Criteria:
State: Tennessee
County: Rutherford County
ID #: All

Results: 1 records found.

Name	ID#	Type	Score	Designation Date	Update Date
Rutherford County					
Christiana Division Service Area	03259	MUA	56.90	1994/05/12	

NEW SEARCH MODIFY SEARCH CRITERIA

Service Area ASTC's
Pain Management

2009	Co.	ORs	PRs	T RM	PM Pts	Total Pts	Pt %	PM Proc	Total Proc	Proc %	Proc./RM
Baptist Ambulatory Surgery Ctr	Davidson	6	1	7	1,152	7,680	15.0%	2,149	16,670	12.9%	2,381
Baptist Plaza Surgicare	Davidson	9	1	10	1,109	9,922	11.2%	3,436	24,153	14.2%	2,415
Centennial Surgery Ctr	Davidson	6	2	8	564	3,633	15.5%	2,415	13,471	17.9%	1,684
Northridge Surgery Ctr	Davidson	4	1	5	836	3,789	22.1%	2,201	11,202	19.6%	2,240
Premier Orthopaedic Surgery Ctr	Davidson	2	0	2	248	2,425	10.2%	638	5,317	12.0%	2,659
Premier Radiology Pain Management Ctr	Davidson	0	2	2	4,156	4,156	100.0%	4,984	4,984	100.0%	2,492
St. Thomas Campus Surgicare	Davidson	6	1	7	1,676	8,028	20.9%	4,007	18,361	21.8%	2,623
St. Thomas Outpatient Neurosurgical Ctr	Davidson	2	2	4	2,197	2,197	100.0%	4,539	4,539	100.0%	1,135
Summit Surgery Ctr	Davidson	5	1	6	2,256	7,279	31.0%	4,470	13,897	32.2%	2,316
Tennessee Pain Surgery Ctr	Davidson	1	3	4	8,685	8,685	100.0%	24,956	24,956	100.0%	6,239
Middle Tennessee ASTC	Rutherford	6	1	7	280	5,385	5.2%	775	10,758	7.2%	1,537
Physicians Pavilion Surgery Ctr	Rutherford	4	1	5	819	3,651	22.4%	1,889	7,754	24.4%	1,551
Surgicenter of Murfreesboro Med. Clinic	Rutherford	4	3	7	0	7,263	0.0%	0	9,027	0.0%	1,290
Cool Springs Surgery Ctr	Williamson	5	1	6	692	6,751	10.3%	1,309	10,491	12.5%	1,749
Crossroads Surgery Ctr	Williamson	*	*	*	*	*	*	*	*	*	*
Williamson Surgery Ctr	Williamson	4	3	7	13	3,680	0.4%	16	6,211	0.3%	887
Total		64	23	87	24,683	84,524	29.2%	57,784	181,791	31.8%	2,090

Legend : ORs = Number of Operating Rooms
PRs = Number of Procedure Rooms
T RM = Total Number of Operating Rooms plus Procedure Rooms
PM Pts = Number of Pain Management Patients
Total Pts = Total Number of patients seen during year
Pt % = Pain Management patients as a Percentage of Total patients
PM Proc = Number of Pain Management Procedures
Total Proc. = Total Number of Procedures Performed during year
Proc % = Pain Management Procedures as a Percentage of Total Procedures
Proc/RM = Total Proc. / T RM

* No JAR

Source: 2009 JAR, Schedule D - Availability and Utilization of Service

Service Area ASTC's
Pain Management Charges

2009	Co.	Gross $	Net $	#Pts	Gross $/Pt	Net $/Pt	#Procs	Gross $/Proc	Net $/Proc
Premier Radiology Pain Management	Davidson	$5,191,138	$3,611,971	4,156	$1,249	$869	4,984	$1,042	$725
St. Thomas Outpatient Neurosurgical	Davidson	$4,915,738	$2,722,359	2,197	$2,237	$1,239	4,539	$1,083	$600
Tennessee Pain Surgery	Davidson	$17,061,613	$12,992,818	8,685	$1,964	$1,496	24,956	$684	$521
Crossroads Surgery	Williamson	*	*	*	*	*	*	*	*
Total		$27,168,489	$19,327,148	15,038	$1,807	$1,285	34,479	$788	$561

2010	Co.	Gross $	Net $	#Pts	Gross $/Pt	Net $/Pt	#Procs	Gross $/Proc	Net $/Proc
Premier Radiology Pain Management	Davidson	$3,179,983	$2,163,383	1,666	$1,909	$1,299	2,751	$1,156	$786
St. Thomas Outpatient Neurosurgical	Davidson	$5,849,686	$2,615,321	2,523	$2,319	$1,037	2,523	$2,319	$1,037
Tennessee Pain Surgery	Davidson	$14,277,365	$3,072,102	2,305	$6,194	$1,333	7,294	$1,957	$421
Crossroads Surgery	Williamson	$590,000	$207,350	220	$2,682	$943	500	$1,180	$415
Total		$23,897,034	$8,058,156	6,714	$3,559	$1,200	13,068	$1,829	$617

2011	Co.	Gross $	Net $	#Pts	Gross $/Pt	Net $/Pt	#Procs	Gross $/Proc	Net $/Proc
Premier Radiology Pain Management	Davidson	$3,680,792	$1,184,882	$2,000	$1,840	$592	3,282	$1,122	$361
St. Thomas Outpatient Neurosurgical	Davidson	$5,811,928	$2,473,977	$2,469	$2,354	$1,002	5,544	$1,048	$446
Tennessee Pain Surgery	Davidson	$13,137,957	$5,378,167	$3,316	$3,962	$1,622	7,848	$1,674	$685
Crossroads Surgery	Williamson	$331,500	$103,089	$116	$2,858	$889	1,560	$213	$66
Total		$22,962,177	$9,140,115	$7,901	$2,906	$1,157	18,234	$1,259	$501

2012 - Provisional	Co.	Gross $	Net $	#Pts	Gross $/Pt	Net $/Pt	#Procs	Gross $/Proc	Net $/Proc
Premier Radiology Pain Management	Davidson	$6,171,671	$1,520,976	1,957	$3,154	$777	3,196	$1,931	$476
St. Thomas Outpatient Neurosurgical	Davidson	$5,457,807	$2,291,681	2,530	$2,157	$906	5,465	$999	$419
Tennessee Pain Surgery	Davidson	$14,637,835	$5,604,720	2,847	$5,141	$1,969	8,960	$1,634	$626
Crossroads Surgery	Williamson	$1,518,879	$286,422	432	$3,516	$663	4,419	$344	$65
Total		$27,786,192	$9,703,799	7,766	$3,578	$1,250	22,040	$1,261	$440

Source: 2009,2010,2012 & 2012(Provisional) JAR, Schedule D - Availability and Utilization of Service & Schedule F - Finacial Data

* No JAR

Supplemental C.N.5.C
SUPPLEMENTAL- # 1
September 30, 2013
11:23am

PROJECTED DATA CHART
(Total Facility)

SUPPLEMENTAL- # 1
September 30, 2013
11:23am

Give information for the two (2) years following the completion of this project. The fiscal year begins in January (month).

		Yr-1	Yr-2
A.	Utilization/Occupancy Rate *(surgical patients))*	3,605	4,627
B.	Revenue from Services to Patients		
	1. Inpatient Services		
	2. Outpatient Services	6,896,975	8,749,490
	3. Emergency Services		
	4. Other Operating Revenue (Specify) _____		
	Gross Operating Revenue	**6,896,975**	**8,749,490**
C.	Deductions from Operating Revenue		
	1. Contractual Adjustments	4,896,852	6,212,137
	2. Provision for Charity Care	356,098	451,349
	3. Provision for Bad Debt	298,379	377,779
	Total Deductions	**5,551,329**	**7,041,265**
	NET OPERATING REVENUE	**1,345,646**	**1,708,225**
D.	Operating Expenses		
	1. Salaries and Wages	125,000	128,750
	2. Physician's Salaries and Wages (Medical Director)	337,500	357,750
	3. Supplies	148,000	169,533
	4. Taxes	25,800	34,533
	5. Depreciation	11,316	11,316
	6. Rent	39,633	40,380
	7. Interest, other than Capital		
	8. Management Fees:		
	a. Fees to Affiliates		
	b. Fees to Non-Affiliates		
	9. Other Expenses (Specify) office supplies, advertising, insurance, utilities	138,800	138,800
	Total Operating Expenses	**826,049**	**881,062**
E.	Other Revenue (Expenses)-Net (Specify)		
	NET OPERATING INCOME (LOSS)	**519,597**	**827,163**
F.	Capital Expenditures		
	1. Retirement of Principal		
	2. Interest (on Letter of Credit)		
	Total Capital Expenditure		
	NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	**519,597**	**827,163**

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in Rule 68-11-1609(c): 12/2013.

Assuming the CON approval becomes the final agency action on that date; indicate the number of day **from the above agency decision date** to each phase of the completion forecast.

Phase	DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1. Architectural and engineering contract signed		
2. Construction documents approved by the Tennessee Department of Health		
3. Construction contract signed		
4. Building permit secured		
5. Site preparation completed		
6. Building construction commenced		
7. Construction 40% complete		
8. Construction 80% complete		
9. Construction 100% complete (approved for occupancy (renovation)		
10. *Issuance of license	60	02/2014
11. *Initiation of service	60	02/2014
12. Final Architectural Certification of Payment		
13. Final Project Report Form (HF0055)		

*** For projects that do NOT involve construction or renovation : Please complete items 10 and 11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

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SEP 30 2013 AM11:18

3298

SUPPLEMENTAL- # 1

September 30, 2013
11:23am

Affidavit of Publications

Newspaper: THE TENNESSEAN

State Of Tennessee

TEAR SHEET
ATTACHED

Account Number: 496359
Advertiser: E GRAHAM BAKER, JR.

RE: MAU OF MIDDLE TN - NOI

I, J Levy **Sales Assistant** for the above mentioned newspaper, hereby certify that the attached advertisement appeared in said newspaper on the following dates:

8/10/2013 J Levy

Subscribed and sworn to me this 14 day of Aug, 2013

Lola Bates

NOTARY PUBLIC